UNITED STATES DISTRICT COURT

FOR THE MIDDLE DISTRICT OF FLORIDA

TAMPA DIVISION

8:09CV1625-T26 AEP

UNITED STATES OF AMERICA *EX REL.* DR. DARREN A. SEWELL, AND STATE OF FLORIDA *EX REL.* DR. DARREN A. SEWELL PLAINTIFF, v. FREEDOM HEALTH, INC., AMERICA'S 1ST CHOICE HOLDINGS OF FLORIDA LLC, LIBERTY ACQUISITION GROUP LLC, HEALTH MANAGEMENT SERVICES OF USA LLC, GLOBAL TPA LLC, DR. KIRANBHAI C. PATEL, AND DR. DEVAIAH PAGIDIPATI, DEFENDANTS.	CASE NO. COMPLAINT FOR VIOLATION OF FEDERAL AND STATE FALSE CLAIMS ACTS JURY TRIAL DEMANDED **FILED IN CAMERA & UNDER SEAL** **(AS REQUIRED BY 31 U.S.C. § 3730(b)(2))**

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COMPLAINT

For their complaint, the United States of America ex rel. Dr. Darren A. Sewell, M.D. (the "United States") and the State of Florida ex rel. Dr. Darren A. Sewell, M.D. (the "State of Florida") allege as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States and the State of Florida (collectively the "Real Parties") under the Federal False Claims Act, 31 U.S.C. §§ 3729–33 (the "FCA"), and the Florida False Claims Act, Fla. Stat. §§ 68.081–.092 (the "FFCA"), against Freedom Health, Inc., America's 1st Choice Holdings of Florida LLC, Liberty Acquisition Group LLC, Health Management Services of USA LLC, Global TPA LLC, Dr. Kiranbhai C. Patel, and Dr. Devaiah Pagidipati ("Defendants").

2. Freedom Health, Inc. ("Freedom") was founded in 2004 as a private managed care organization covering health insurance benefits for Medicare beneficiaries, pursuant to a contract with the Centers for Medicare and Medicaid Services ("CMS"), the federal agency that administers Medicare. The Medicare Advantage ("MA") program, through which Freedom offers its health plans, is designed to apply to Medicare a form of the "managed care" model commonly used by private health insurance companies. Under the managed care model, rather than paying for individual services one at a time as they are delivered to beneficiaries, the managed care organization pays a fixed amount each month for each individual "member" of the plan—commonly called a monthly "capitation" payment. The entity receiving this capitation payment (often a hospital,

physician group, or another health insurance company) is responsible for paying hospitals, physicians and all other medical providers for health care services provided to a member of the plan.

3. Through the MA program, Medicare allows private health insurers to set up managed care plans to cover Medicare beneficiaries. Medicare pays a monthly capitation rate for each beneficiary enrolled as a member of a MA plan. MA plans must then use that money to pay hospitals, physicians and other health care providers for the services the plan members receive.

4. Freedom entered into a contract with CMS to operate MA plans in 2005, and the contract, following annual renewals, remains ongoing. In each year of its existence, Freedom has received 99% of its total revenue from Medicare premiums, which totaled $181.8 million in 2008, and $161.1 million in the first half of 2009. Freedom similarly contracted with CMS and the Florida Agency for Health Care Administration ("AHCA") to allow Florida Medicaid recipients to enroll in Freedom's managed care plans. There are currently approximately 3,700 Medicaid recipients enrolled in Freedom's plans.

5. Strict rules govern the management of MA plans to ensure both that the Medicare beneficiaries receive the heath care they need, and that the Federal and State governments do not overpay for these services. Defendants have consistently and deliberately violated those program rules in order to fraudulently increase their profits, and in the process have deprived the sickest of their members of the medical care to which they were entitled.

6. From the outset, Freedom has used a variety of discriminatory enrollment practices to minimize its risk and increase its profitability by gaming the capitation system. Freedom manipulates its membership and enrollment policies to fraudulently avoid responsibility for the most expensive members, while hoarding the money it earned from the least expensive members. Freedom's fraudulent practices include, *inter alia*: (a) selectively disenrolling sick (expensive) members from its MA plans; (b) encouraging sick, costly members to disenroll from its plans; and (c) selectively concealing from CMS enrollment mistakes that, if corrected, would have required it to reimburse CMS for costly claims.

7. In addition to its standard MA plans, Freedom contracted with CMS to operate Special Needs Plans ("SNPs") for its chronically ill and/or especially vulnerable beneficiaries. SNPs are supposed to provide extra health care services and management to better facilitate care for these at-risk beneficiaries. Thus for example, an SNP might provide special disease management and care tracking programs for patients with conditions such as diabetes in order to ensure the patient is compliant with dietary and blood sugar management protocols. Because such plans are specifically designed to serve sicker members, the capitation rates are frequently higher than for non-SNP plans.

8. Freedom also manipulated its enrollment and disenrollment policies for its SNPs to fraudulently increase its revenue and decrease its costs. As with its regular MA plans, Freedom improperly kicked sick enrollees out of its SNPs in order to game the capitation rate system. In addition, Freedom enrolled relatively healthy individuals as

members of its SNPs in order to get the enhanced capitation rate CMS was paying Freedom for its SNPs.

9. Freedom has also knowingly failed to provide its members with basic care services that it was contractually and legally obligated to provide as part of its MA contract and under CMS regulations. Freedom also secured CMS's approval to operate SNPs by falsely representing in its solicitations that it would offer services it had no intention of actually providing, and has not in fact provided.

10. Finally, Freedom fraudulently induced CMS to authorize it to expand its service area. As a precondition to any such service area expansion, a plan is required to demonstrate that it has in place a sufficient network of doctors, clinics, and hospitals available to serve enrollees in the expanded service areas. Freedom had no such network in place when it applied to expand its service area, but fraudulently induced CMS to approve its application by listing in its applications a rented network of health care providers that it did not intend to use in practice, and in fact has not utilized since CMS approved its applications.

11. Through each of these fraudulent schemes, practices and machinations Freedom has illegally sought and obtained higher capitation rates than it was entitled to receive, and has fraudulently refused to provide services that the United States and Florida paid it to provide.

12. The Federal and Florida False Claims Acts provide that any person who knowingly submits or causes to be submitted a false or fraudulent claim to a governmental entity for payment or approval is liable for a civil penalty of up to $11,000

for each such claim, plus three times the amount of the damages suffered by the government. The Acts allow any person having information regarding a false or fraudulent claim against the government to bring an action on behalf of himself (the "*qui tam* plaintiff" or "relator") and the government and to share in any recovery.

13. Based on these provisions, *qui tam* plaintiff Dr. Darren A. Sewell, M.D. seeks to recover damages and civil penalties arising from Defendants' actions in presenting false claims for payment and approval, false records, and false statements to the United States and the State of Florida, and in avoiding known obligations to pay money to the United States.

II. PARTIES

14. *Qui tam* plaintiff Dr. Darren A. Sewell, M.D. ("Relator") is a resident of St. Petersburg, Florida and an employee of Defendant Global TPA, LLC ("Global TPA"), a management entity that staffs Defendant Freedom Health, Inc. ("Freedom"). Freedom hired Relator as a consultant in November 2007, before hiring him full-time in February 2008 as its Chief Medical Officer/Senior Vice President of Health Services, a title that was shortened in April 2008 to Senior Vice President of Health Services, and which he continues to hold today. As head of the Health Services Department, the department in charge of making clinical decisions, Relator is responsible for overseeing the administration of medical benefits in order to ensure the delivery of health care services through Freedom's benefit structure. Relator works closely with Freedom's Pharmaceutical Department, Provider Operations Department, and Medical Risk Adjustment Department. Relator reports to Siddhartha ("Sidd") Pagidipati, Freedom's

Chief Operating Officer. Prior to working for Freedom, Relator held senior positions in two other health maintenance organizations, serving as Vice President of Health Services for Universal Health Care, Inc. in St. Petersburg, Florida, and before that as Medical Director for PacifiCare Health Care Systems, Inc. in Denver, Colorado.

15. Real Parties, on whose behalf Relator brings this suit, are the United States and the State of Florida. The United States has ongoing contracts with Defendant Freedom through the Centers for Medicare and Medicaid Services ("CMS") of the Department of Health and Human Services, in accordance with Freedom's participation in the Medicare and Medicaid programs. The State of Florida has contracts with Freedom through the Agency for Health Care Administration ("AHCA"), pursuant to Freedom's participation in the Medicaid program, and, pertinently to this case, is required to make monthly payments to Freedom for Medicaid benefits that Freedom contracted to cover as part of its Medicare special needs plan for beneficiaries dually-eligible for Medicare and Medicaid.

16. Defendant Freedom Health, Inc. ("Freedom") is a Florida corporation with its principal place of business in Tampa, Florida. Freedom is a health maintenance organization ("HMO"), operating in thirty counties throughout Florida pursuant to a certificate of authority from the Florida Office of Insurance Regulation and the approval of CMS and AHCA. Freedom employs few workers, having contracted with Defendant Global TPA to supervise and manage its day-to-day operations. Like Global TPA, Freedom's sole owner is Defendant America's 1st Choice Holdings of Florida, LLC, a holding company controlled by Defendant Dr. Kiranbhai ("Kiran") C. Patel.

17. Defendant America's 1st Choice Holdings of Florida, LLC is a Florida Limited Liability Company controlled by Dr. Kiran C. Patel that is the sole owner of both Freedom and Freedom's management company, Global TPA. Its principal place of business is in Tampa, Florida.

18. Defendant Liberty Acquisition Group, LLC is a Florida Limited Liability Company controlled by Dr. Kiran C. Patel that owns 55% of America's 1st Choice Holdings of Florida, LLC. Its principal place of business is Tampa, Florida.

19. Defendant Health Management Services of USA, LLC is a Nevada Limited Liability Company controlled by Defendant Dr. Devaiah Pagidipati that owns 20% of America's 1st Choice Holdings of Florida.

20. Defendant Global TPA, LLC ("Global TPA") is a Florida Limited Liability Company with its principal place of business in Tampa, Florida. Global TPA operates under a contract with Freedom to supervise and manage Freedom's day-to-day operations, including utilization management, grievances and appeals, marketing and enrollment, administrative services and contracts management, information systems management and reporting, member services, provider relations and network development, provider credentialing and re-credentialing, and claims management. As such, Global TPA technically employs the majority of Freedom's workers and is responsible for the bulk of Freedom's operations. Global TPA's sole owner is America's 1st Choice Holdings of Florida, LLC, a holding company controlled by Dr. Kiran C. Patel.

21. Defendant Dr. Kiranbhai C. Patel ("Dr. Patel"), known as "Kiran C. Patel" or colloquially within Freedom as "Dr. K," is a resident of Tampa, Florida. Dr. Patel is a physician who emigrated from India and established a cardiology practice in the Tampa area in the early 1980s. Dr. Patel has founded several businesses, most prominently WellCare HMO, Inc., an HMO that Dr. Patel established in 1992 and sold in 2002 for an estimated $200 million. The terms of the WellCare sale excluded Dr. Patel from the HMO market for five years, during which time he invested in several large real estate ventures. Upon the expiration of his non-compete provision in 2007, Dr. Patel purchased Defendant Freedom and another Tampa-area HMO, Optimum Healthcare, Inc., in a deal worth $50 million. Following the purchase, Dr. Patel assumed the titles of Freedom's President and CEO. Dr. Patel controls Freedom through his control of Defendant Liberty Acquisition Group, LLC, a holding company that owns a majority of Defendant America's 1st Choice Holdings of Florida, LLC, the holding company that, in turn, owns Defendants Freedom and Global TPA. Dr. Patel is 60 years old.

22. Defendant Dr. Devaiah Pagidipati, known colloquially within Freedom as "Dr. P," is a physician who emigrated from India in the 1970s and established a pediatric anesthesiology practice in Tennessee before later moving to Florida. Dr. Pagidipati is now a resident of Ocala, Florida. Dr. Pagidipati founded Freedom Health, Inc. in 2004, along with his son, Sidd Pagidipati. Dr. Pagidipati relinquished his positions as President and CEO of Freedom when he sold the company to Dr. Patel in 2007, but retained a 20% ownership interest in Freedom through his control of Health Management Services of

USA, LLC. Dr. Pagidipati also retained a position on Freedom's board of directors, which he continues to hold. Dr. Pagidipati is approximately 60 years old.

III. JURISDICTION AND VENUE

23. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a), which specifically confers jurisdiction on this Court for actions brought under 31 U.S.C. § 3730.

24. This Court has supplemental jurisdiction, pursuant to 28 U.S.C. § 1367, over the Relator's state law claims, as those claims and the Relator's federal law claims are sufficiently related to form part of the same case or controversy under Article III of the United States Constitution. This Court has supplemental jurisdiction over the State of Florida's claims pursuant to 31 U.S.C. § 3732(b), as the State of Florida's claims arise from the same transactions and occurrences as the federal action.

25. This Court has personal jurisdiction over the Defendants, pursuant to 31 U.S.C. § 3732(a), as one or more Defendants can be found in, reside in, transact business in, and have committed acts related to the allegations in this Complaint in the Middle District of Florida. Defendant Freedom Health, Inc. is a Florida corporation with its principal place of business in Tampa, Florida. Defendants America's 1st Choice Holdings of Florida, LLC, Liberty Acquisition Group, LLC, and Global TPA, LLC, are each Florida Limited Liability Companies with a principal place of business in Tampa, Florida. Individual Defendants Dr. Kiran C. Patel and Dr. Devaiah Pagidipati are both Florida residents.

26. Venue is proper, pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b)–(c), as the Defendants can be found in, reside in, and/or transact business in the Middle District of Florida, and because many of the violations of 31 U.S.C. § 3729 discussed herein occurred within this judicial district.

IV. THE FEDERAL FALSE CLAIMS ACT

27. The False Claims Act, as amended by the Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21, provides in pertinent part that:

> [A]ny person who (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit a violation of subparagraph (A), (B), . . . or (G); . . . or (G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 . . . plus 3 times the amount of damages which the Government sustains because of the act of that person.

31 U.S.C. § 3729(a)(1).

> A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. . . .

31 U.S.C. § 3730(b)(1).

V. THE FLORIDA FALSE CLAIMS ACT

28. The Florida False Claims Act provides in pertinent part that:

> Any person who: (a) Knowingly presents or causes to be presented to an officer or employee of an agency a false or fraudulent claim for payment or approval; (b) Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by an agency; (c) Conspires to submit a false or fraudulent claim to an agency or to deceive an agency for the purpose of getting a false or fraudulent claim allowed or paid; . . . or (g) Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to an agency, is liable to the state for a civil penalty of not less than $5,500 and not more than $11,000 and for treble the amount of damages the agency sustains because of the act or omission of that person.

Fla. Stat. § 68.082(2).

> A person may bring a civil action for a violation of § 68.082 for the person and for the affected agency. . . .

Fla. Stat. § 68.083(2).

VI. THE MEDICARE ADVANTAGE PROGRAM

29. Medicare is a federally-funded health care program primarily serving people age 65 or older. Initially created in Title XVIII of the Social Security Act of 1965, Medicare now has four Parts, A through D. The two original components of Medicare are Part A, which covers inpatient hospital costs and related services, and Part B, which covers outpatient health care costs, such as physicians' fees. Medicare Part D was created by the Medicare Prescription Drug, Improvement, and Modernization Act established in 2003 ("MMA"), and covers prescription drugs.

30. Traditionally, Medicare operates on a fee-for-service basis, meaning that Medicare directly pays hospitals, physicians and other health care providers for each service they provide to a Medicare beneficiary. Medicare beneficiaries are generally

required to pay some portion of many of these services in the form of copayments, deductibles, coinsurance, or other set fees (collectively known as the members "out of pocket" expenses).

31. In 1997, Congress created Medicare Part C, which provides the same benefits to Medicare members, but does so based on a managed care model, rather than the traditional fee-for-service model. Under Part C, rather than pay providers directly, Medicare pays managed care plans (later named "Medicare Advantage" or "MA" plans) a fixed capitation rate (per member per month) and those plans are responsible for paying providers for the services they provide to members of that specific MA plan.

32. MA plans must provide Medicare beneficiaries at least the same benefits they would have received under the traditional Medicare Parts A and B. Depending on the structure of the plan, MA plans may also provide additional benefits beyond what traditional Medicare would have covered, such as dental care, or cover some or all of their members' out of pocket expenses associated with basic Medicare Parts A and B services or Part D prescription drugs.

A. Calculation of MA Plan Capitation Rates

33. The capitation rates Medicare pays to MA plans are determined based on a complicated process involving consideration of past and expected future medical expenses, the location of the plan's actual and expected members, the health status of those members and whether the plan will include any additional benefits. That process is summarized in Medicare regulations as follows:

> In short, under the bidding methodology each plan's bid for coverage of Part A and Part B benefits (*i.e.*, its revenue requirements for offering

> original Medicare benefits) is compared to the plan benchmark (*i.e.*, the upper limit of CMS' payment, developed from the county capitation rates in the local plan's service area or from the MA regional benchmarks for regional plans). The purpose of the bid-benchmark comparison is to determine whether the plan must offer supplemental benefits or must charge a basic beneficiary premium for A/B benefits.

Medicare Managed Care Manual ("MMCM"), ch. 8, § 60.

34. In other words, it is a three step process involving: (a) development of the MA plan's bid rate; (b) development of the CMS benchmark rate; and (c) comparison of those two rates to develop the base capitation rate and determine whether any adjustments in the plan benefits or member premiums are required.

35. First, the MA plan develops a bid rate. This rate is the amount that the MA plan expects it will be required to pay to provide Medicare Parts A and B benefits to a hypothetical average member of the plan. This estimate must be based on either the MA plan's prior experience covering Medicare members, or on actuarially validated data analysis of expected costs. To represent an "average" plan member, the bid rate must make adjustments to standardize the effect of expected geographic diversity (because some areas are more expensive than others) and the relative health status (*i.e.*, the number and nature of chronic conditions) of the members whose claims experience provided the basis for the bid. The bid rate also includes an amount that the MA plan expects to spend on administrative costs, and a profit margin.

36. The mechanism for standardizing the bids by geographic area is known as the ISAR Factor. Medicare has determined that providing services to its members in certain counties tends to cost more than providing such services to members in other counties—either because the care is more expensive or because more care is required.

Medicare has established tables which can be used to determine how expensive care is in one county versus another. When developing their bid rate, MA plans must use these tables to develop a rate that would be required to provide care to a hypothetical member in a county where care for Medicare members costs an "average" amount.

37. The mechanism for standardizing the bid for individuals' health status is known as the "risk score" or CMS—Hierarchical Condition Category ("CMS—HCC"). It is an artificial score that CMS assigns to every beneficiary. CMS starts with a score of zero, and then adds points for the beneficiary's demographic condition (such as age and gender) and individual disease states (such as diabetes or heart failure). The average CMS—HCC score is one, with most Medicare beneficiaries having scores under three. Thus someone with a risk score of two would be expected to need twice as much health care (in dollars) as someone with a score of one. The bid rate the MA plans develop must reflect the amount they will require to provide services to a hypothetical member with a risk score of one.

38. Second, the MA plan must calculate the appropriate Medicare benchmark rate. This rate is calculated using data provided by CMS about the amount that the Medicare program would spend to provide Parts A and B benefits to an average member in the geographic area covered by the MA plan's bid. This benchmark rate is based on the amount Medicare would pay for a member of standard health status (*i.e.*, a risk factor of one). The benchmark rate also includes several other adjustments, including a bonus payment to incentivize health insurance companies to enter the MA market.

39. Third, the bid rate and the benchmark rate are compared to determine whether the MA plan must charge its members a premium, or, instead, if it must offer them enhanced benefits. If the bid rate is greater than the benchmark rate, Medicare will only pay the MA plan the benchmark rate per member per month. That benchmark rate becomes the base capitation rate. The MA plan must then charge the beneficiaries who join its plan a monthly premium in order to make up the shortfall between the bid rate and the base capitation rate. *See* MMCM, ch. 8, § 60.1.

40. If, on the other hand, the bid rate is less than the benchmark rate, then the bid rate becomes the starting point for the calculation of the base capitation rate. The difference between the benchmark rate and the bid rate is then split between the plan members and the Medicare program. The first 25% of the difference is retained by the Medicare program as plan savings. The remaining 75% is returned to the MA plan, which must use the rebate to either provide enhanced benefits to its plan members or to cover the members' out of pocket expenses. In the end, then, in such situations, the base capitation rate equals the bid rate plus 75% of the difference between the bid rate and the benchmark rate.

41. Medicare does not, however, pay the plans the base capitation rate. Instead, when payments are actually made, the base capitation rate is adjusted, for each member, to reflect his or her geographic ISAR score (based on the county where they live) and risk score (based on their health status).

42. Consequently, MA plans whose members live in relatively expensive counties will receive a higher actual capitation rate than another plan, even if both plans

had the same base capitation rate. So too, MA plans with a high percentage of members with high risk factors will have a higher actual capitation rate than MA plans with healthier, lower-risk members, even if their base capitation rate is the same.

43. MA plans must rebid their rates every year.

44. In the short term, MA plans stand to lose money if their members require more services (in dollars) than the capitation rate, because they are only paid the capitation rate regardless of the actual cost of claims. They also stand to gain if the members require less expensive care, because the plan may retain the difference between the capitation rate and the costs of paying claims. Over the long term, these effects tend to be mitigated because future years' rates are based on the present year's claims experience. Thus plans that experience unexpectedly high claims expense in year one, will generally see higher reimbursement in year two, and so forth.

B. Special Needs Plans

45. The 2003 Medicare Prescription Drug, Improvement, and Modernization Act ("MMA") also created Special Needs Plans ("SNP") to treat the sickest and most vulnerable Medicare beneficiaries. There are three SNP types: (1) for institutionalized beneficiaries, (2) for beneficiaries eligible for both Medicare and Medicaid, and (3) for beneficiaries with severe or disabling chronic conditions.

46. Unlike general MA plans, which must enroll and be marketed to the general population of Medicare beneficiaries, a SNP is limited to its statutorily-defined target population. MA plans may not enroll non-target group members into their SNPs.

47. MA organizations can market SNPs directly to these target groups, such as diabetics. Plans cannot "cherry pick" within a target group: they must enroll anyone who is eligible for the SNP, no matter how healthy or how sick.

48. The purpose of the SNP program is to improve care for vulnerable populations by improving coordination and continuity of care. SNPs are expected to improve the benefits available to their members, either by combining Medicare and Medicaid benefits for dual-eligible beneficiaries, or by managing chronic disease through health status and treatment monitoring, with an eye toward improving chronically-ill members' health outcomes. CMS measures SNP service delivery and outcomes through reporting requirements, which it oversees with the help of an outside contractor, the National Center for Quality Assurance ("NCQA").

49. MA organizations submit bids for their SNPs separately from their regular MA plans, owing to the special services they provide SNP members. Because SNPs serve populations that typically require more care than the general population, their capitation rates are frequently higher than for non-SNP plans.

50. Such has been the case for Freedom. In 2008, Freedom estimated it would receive $220 to $236 more per member per month for its SNP members, compared to the members in its non-SNP, general MA plans. Exhibit 2, incorporated herein.

C. MA Member Enrollment Rules Designed to Prevent Manipulation of Capitation Rates

51. CMS rules and the contracts between CMS and individual plans require MA plans to adhere to (and certify their adherence to) several requirements with respect to who enrolls in the plan, how they are enrolled, and what services will be provided to

those members. Generally speaking, these rules require MA plans, such as Freedom, to accept any Medicare beneficiary who is eligible to enroll, without regard for preexisting health condition or prior claims experience. Thus plans are flatly prohibited from discriminating on the basis of health in their enrollment and disenrollment activities, and cannot encourage members to disenroll from the plan for any reason.

52. The prohibition against discrimination on the basis of health status, age or other condition is an essential component of any health care program that depends on monthly capitation rates as a means of reimbursement. Such monthly rates are based on average costs per member per month, and thus recognize that some members will require more care than the capitation rate will cover, but others (most others) will require less care. In fact, as a general rule, a small segment of the membership of most managed care plans—the sickest members—generally account for a substantial portion of all of the health care expenses for the entire plan. Accordingly, a substantial portion of the capitation rate for each member is actually attributable to the expected cost of treating those few sickest patients.

53. For this reason, a managed care plan that "cherry picks" its members by excluding the sickest members will receive a windfall because it is being paid based on an assumption that the profits it makes on the majority of members will be offset by the loss it will take on those sick members. Thus, the prohibition against cherry picking in the contracts between MA plans and CMS is an essential component of the program, without which the capitation-rate-setting process does not work.

54. This principle applies with particular force when capitation rates are adjusted by a risk factor, such as the one used for MA plans, that reflects the patient's health status, but does not account for past claims. This is so because risk status does not necessarily predict how much and how many health care services a patient will require. For example, patients with diabetes are generally classified as higher risk than patients without diabetes. Yet there is substantial variation among diabetes patients as to their health needs. A patient who attentively manages his or her blood sugar level, and otherwise lives a healthy life, may require little extra treatment compared to a non-diabetic. On the other hand, a patient who fails to monitor or control his or her blood sugar levels, regularly consumes alcohol and sugary foods, and otherwise lives a lifestyle that is incompatible with diabetes, will likely require substantially more care, often including multiple hospitalizations or surgical intervention. Thus two patients with the same overall risk score may cost a plan substantially different amounts in claims expense.

55. In general, the use of risk status rather than claims experience encourages honest plans to manage their patients' health care more aggressively. Because CMS calculates risk adjustment by disease states, and not claims history, MA organizations will lose money on beneficiaries whose claims exceed their risk-adjusted Medicare premiums. Even the highest risk-adjusted annual premium will generally not cover three or four average hospitalizations. Conversely, MA organizations that successfully reduce the claims volume/cost of their sickest beneficiaries will make a profit on them, as CMS will continue to calculate the beneficiaries' premiums by their multiple disease states, and

not by their low claims expense. The risk adjustment system, therefore, rewards MA organizations that improve their members' health outcomes.

56. However, unscrupulous plans could manipulate this system if they were able to pick and choose their patients based on claims experience rather than just based on health status. By so doing, plans could select the patients who have a high risk score—and a correspondingly high capitation rate—but who have not, in fact, historically required expensive care. These plans would then shift the cost of caring for the more expensive patients either to other, honest plans or to traditional Medicare Parts A and B.

57. Another rule that prevents cherry picking is the requirement that members may only join or leave MA plans at certain limited times, or under certain conditions. These rules are necessary to prevent a member—whether on their own or under pressure from the plan—from switching from one plan to another, or to standard Medicare, when they need expensive care.

58. CMS has established fixed procedures for when and how MA organizations may enroll and disenroll Medicare beneficiaries. To keep Medicare beneficiaries from continually revolving from plan to plan, or from plans to original Medicare, CMS created limited windows during which beneficiaries may elect to enroll or disenroll. These enrollment windows include the Annual Election Period ("AEP") from November 15 to December 31, in which beneficiaries can freely move in or out of MA plans, and the Open Enrollment Period ("OEP"), from January 1 to March 31, in which beneficiaries are allowed to make a single election to enroll or disenroll from an MA plan. Special Election Periods ("SEP") also create a fixed window of time for

beneficiaries whose status has changed, such as by moving to a new county or losing coverage through their employer, to enroll in an MA plan.

59. CMS has created an SEP for beneficiaries to enroll in a severe or disabling chronic condition SNP. This SEP lasts as long as the beneficiary has the qualifying chronic condition, ending only once the beneficiary has enrolled in the SNP. In other words, so long as he or she has never enrolled in a SNP before, a person with a qualifying condition can enroll in a chronic care SNP any time throughout the year. As will be discussed herein, Freedom capitalized on this SEP during the spring and summer of 2008 by enrolling thousands of beneficiaries into its SNPs, when its other, general MA plans were closed to open enrollment.

D. CMS Requires MA Plans To Certify the Validity of Their Bid Rates and Supporting Data To Prevent Fraud

60. In recognition of the fact that the integrity of the capitation rates depends on the integrity of the actuarial information used by the MA plans in developing their bid rates, and to otherwise guard against fraud, CMS requires MA organizations to submit three separate attestations, each signed by the CEO or CFO (or their authorized, direct subordinate). These attestations are a condition that the MA plans must meet to be eligible to receive any capitation payments from CMS.

61. The first attestation, which the MA organization submits on a monthly basis, requires the MA organization to "attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization."

62. The second attestation, which is submitted annually, requires the MA organization to attest that the risk adjustment data it submits annually to CMS is "accurate, complete, and truthful."

63. The third attestation is the MA organization's certification "that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposal bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposal bid submission." Exhibit 1, incorporated herein.

VII. FRAUD AGAINST REAL PARTIES

64. Freedom Health, Inc. ("Freedom") was founded in 2004 by Dr. Devaiah Pagidipati and his son, Siddharta ("Sidd") Pagidipati. Devaiah Pagidipati is a Tampa-area entrepreneur and former physician who began his medical career as a pediatric anesthesiologist soon after emigrating from India in the early 1970s. Sidd Pagidipati is a former investment banker who moved from New York to Tampa to run the new company. Unlike his father, Sidd had no experience in health care, and neither father nor son had experience in running a health plan. To provide health plan expertise for the new company, Sidd recruited several executives from WellCare HMO, Inc. ("WellCare"), a large health plan founded by Dr. Kiran C. Patel in the 1990s. These executives included Christopher O'Connor, his wife Lucy O'Connor, and Tammy Castano. At the outset, Devaiah Pagidipati was Freedom's President and Chief Executive Officer ("CEO") and Sidd Pagidipati the Chief Operating Officer ("COO").

65. Florida health plans such as Freedom cannot provide coverage to Medicare beneficiaries unless they have a health care provider certificate from the State of Florida's Agency for Health Care Administration ("AHCA") and enter into a Medicare coordinated care plan contract with the federal Centers for Medicare & Medicaid Services ("CMS"). Freedom executed its first contract with CMS on July 8, 2005, with an effective date of September 1, 2005.

66. To succeed, Freedom knew it had to grow rapidly. Like other startup health plans, Freedom was competing against Universal Healthcare, a plan that offered beneficiaries cash-back worth their monthly Medicare Part B premium, and whose membership had doubled every year of its existence. To replicate this level of growth, Freedom emulated Universal Healthcare's business model by offering its enrollees a complete refund on their Part B premiums. The growth plan was successful, with Freedom enrolling 4,000 members in its first year. By 2006, Freedom had expanded from three counties, Marion, Broward, and Miami-Dade, to ten, including Hillsborough, Pasco, Pinellas, and Hernando counties. Its staff had grown to eighty employees, split between two rented offices in St. Petersburg and Clearwater. Still, Freedom was a small plan compared to others in the region, such as Universal Healthcare, which could boast a membership of almost 100,000.

67. It was Freedom's position as a small but fast-growing company that attracted the interest of Dr. Kiran C. Patel. Dr. Patel understood how to grow health plans, having co-founded WellCare in 1992, which he quickly built into a billion-dollar-revenue company before selling it in 2002 for an estimated $200 million. Like Devaiah

Pagidipati, Dr. Patel was originally a practicing physician, having emigrated from India and established a cardiology practice in the Tampa area in the early 1980s. A non-compete agreement from the WellCare sale kept Dr. Patel out of the health insurance market for five years, but upon its expiration he promptly moved to replicate his WellCare success by buying Freedom and another small health plan, Optimum Healthcare, Inc., for an estimated $50 million in November 2007. In Freedom, Dr. Patel saw an opportunity to swiftly grow the business, using skills he had developed at WellCare, after which he could "flip" the expanded company, selling it for a quick profit.

68. Freedom's founders, the Pagidipatis, allowed Dr. Patel to buy the company because he had the financial resources needed to accelerate Freedom's growth. Following the sale, Dr. Patel became Freedom's new President and CEO, while Sidd Pagidipati remained Freedom's COO. Devaiah Pagidipati, Freedom's former President and CEO, remained on the board of directors. Dr. Patel invested $6,100,000 in Freedom in 2007.

69. Freedom had ambitious growth targets from its inception, and these only increased under Dr. Patel. Dr. Patel expected Freedom to double its revenue within the first year of his ownership. Freedom had 12,554 members at the end of 2007; Dr. Patel wanted it to have 50,000 within three years. Freedom seemed poised to achieve that target, as it nearly doubled its membership during the 2007–2008 Medicare open enrollment period, boasting over 24,000 members in May 2008. The staff had more than doubled (from eighty to 190) by that point, and Dr. Patel expected to hire another 25–50

by the beginning of the 2009 open enrollment period. Expansion, however, did not bring immediate profits. Freedom lost $10.7 million in 2007 on $98.4 million in revenue.

70. In August 2009, Freedom was the seventh-fastest-growing company in America, according to Inc. Magazine. Freedom's revenue growth between 2005 and 2008 was an astonishing 10,035.3%.

71. During 2007 and 2008, it was widely known among Freedom's managers that Dr. Patel had set a target for Freedom to grow to $50 million in earnings before interest, taxes, depreciation, and amortization ("EBITDA")—the size at which it would become valuable enough to attract potential buyers—as quickly as possible. It was also well known that Dr. Patel would sell Freedom once it reached this target, just as he had done with WellCare. Dr. Patel's plan set the tone for the entire company. To those who own and manage it, Freedom is a revenue engine first, and a health insurer second. Because they hope to sell Freedom once it reaches their earnings target, they have no incentive to worry about improving long-term health outcomes, focusing instead on enrollment growth and short-term profitability. As will be discussed below, Freedom pursues these two goals at every turn, often taking shortcuts at the expense of Medicare beneficiaries.

72. In an attempt to meet Dr. Patel's aggressive growth and earnings targets, Freedom has engaged in a wide-ranging and opportunistic pattern of fraud. Freedom's fraudulent activities fall into two basic categories. First, Freedom has turned the idea of health insurance on its head, and sought to eliminate any element of risk, by engaging in a systemic practice of cherry picking, i.e., identifying sick, costly beneficiaries and

removing them from its plans. Second, subscribing to a theory of "grow the membership first and worry about how to provide services later," Freedom has fraudulently induced approval from CMS to operate its special needs plans ("SNPs") and to expand its service area, by making multiple false representations in its applications regarding its ability to provide the basic services inherent to a SNP plan, or to secure an adequate provider network to support expansion into new counties.

A. Discriminatory "Cherry Picking" to Exclude Unhealthy Beneficiaries

73. To maximize its profit, Freedom has developed several means for discriminating against sick, high-cost beneficiaries, including without limitation by (1) paying sales brokers to encourage expensive members to disenroll, (2) disenrolling its most costly special needs plan ("SNP") beneficiaries, both confirmed and unconfirmed, as "lacking a qualifying condition" for the SNP, while at the same time keeping unconfirmed but healthy beneficiaries in the SNPs long after it should have disenrolled them, (3) in the wake of a provider's termination, directing its member retention efforts to only its healthy, profitable beneficiaries, and (4) during the CMS reconciliation process, concealing from CMS its obligation to reimburse CMS for expensive claims it knew it was responsible for covering.

1. Paying Sales Brokers to Selectively Encourage Expensive, Unhealthy Members to Disenroll

74. Freedom has repeatedly and fraudulently encouraged its high-cost beneficiaries to disenroll from its plans. It has done so by identifying the costliest members in its plans and giving their names to sales brokers, with the expectation that the

brokers would contact the members and encourage them to switch to other health plans, in exchange for a cash payment from Freedom for every patient moved.

75. Removing the costliest beneficiaries from Freedom's plans would yield a sizable profit. Like other health insurers, Freedom turns a profit when its total expenditures are less than the sum of its premiums and payments from Medicare. The level of profit depends on the medical-loss ratio ("MLR"). MLR, also referred to as medical-cost ratio, is the insurer's total inpatient, outpatient, professional, and pharmacy costs divided by its total premiums and health care revenue. The lower Freedom's medical-loss ratio, the higher its profits. Since Freedom charges no premium, its MLR is calculated by dividing its expenses against Medicare's monthly capitation payments.

76. Because large institutional claims, particularly hospitalizations, account for the bulk of a health plan's costs, it would be in the plan's interest to selectively enroll beneficiaries with low claims and avoid beneficiaries who are chronically ill and frequently hospitalized. Therefore, federal law flatly prohibits discrimination on the basis of health status:

> [A]n MA organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following: (1) Medical condition, including mental as well as physical illness. (2) Claims experience. (3) Receipt of health care. (4) Medical history. . . .

42 C.F.R. § 422.110(a). Furthermore, federal law forbids health plans from encouraging their beneficiaries to disenroll: "[A]n MA organization may not orally or in writing, or by

any action or inaction, request or encourage an individual to disenroll." 42 C.F.R. § 422.74.

77. The contracts Freedom signed with CMS required Freedom to certify that it would "comply with the provisions of § 422.110 concerning prohibitions against discrimination in beneficiary enrollment . . . ." *See* Exhibit 1, incorporated herein. Compliance with this anti-discrimination provision is material to Freedom's performance of its CMS contract, and thus to its ability to receive payments. 42 C.F.R. § 422.504(a)(2), (a)(14).

78. In its contract with AHCA, Freedom likewise certified that it would not discriminate in beneficiary enrollment: "The Health Plan shall accept Medicaid Recipients without restriction and in the order in which they enroll. The Health Plan . . . shall not use any policy or practice that has the effect of discriminating on the basis of . . . health, health status, pre-existing condition, or need for health care services." Exhibit 3, incorporated herein. Freedom further certified that it would not engage in "practices that are discriminatory, including, but not limited to, attempts to discourage Enrollment or reenrollment on the basis of actual or perceived health status." *Id.*

79. Encouraging disenrollment, however, was exactly what Freedom did to meet its aggressive profit targets. In late 2007, Sidd Pagidipati and Mital Panara, a Freedom business analyst who works under Sidd's direction in the Operations/Finance/Medical Risk Adjustment Departments, compiled a list of 274 beneficiaries who had cost Freedom over $14 million in claims. In a conversation with Relator on October 13, 2008, Panara explained that Sidd had provided $100 in cash for

every beneficiary that sales agents moved to other health plans. Using three internal sales agents and 3–4 external agents, Freedom had successfully induced 190 of the 274 targeted members to disenroll from its plans, with Sidd funding the scheme and Panara delivering the cash to the sales brokers. *See* Exhibit 4 (Relator's notes dated 10/13/08), incorporated herein.

80. Freedom continued to encourage expensive members to disenroll during 2008 by creating lists of costly members and giving the lists to sales brokers with the promise of a commission for each beneficiary who disenrolled. Sidd instructed Panara and Relator to refer to these lists as "DM lists" to conceal their illicit nature. *See* Exhibit 5 (Relator's notes dated 11/25/08), incorporated herein. Sidd chose the term "DM" because it also refers to disease management, and thus Freedom could explain the lists of unhealthy beneficiaries by saying they were created for disease management purposes, when in fact they were created for targeted disenrollment.

81. Freedom relied on sales broker Jeff Wood for removing expensive members from its plans. Jeff Wood is an independent broker working for Accent and Florida Insurance Group. Sidd Pagidipati and Mital Panara use Wood for their "special projects," foremost among them the removal of members on the DM lists. Though Freedom has occasionally approached other sales brokers, such as Mary Szafranski, a licensed independent broker, and Beverly Parrish, a sales agent for Universal Health Care, Inc., it has depended primarily on Wood, making him an integral part of its efforts to purge expensive members from its rolls.

82. In July 2008, Freedom took a list of active members, each of whom had more than $30,000 in 2007 expenses, identified the 57 most expensive members, and placed them in a separate list titled "for Mary" that included only information a broker would need: name, sex, address, and phone number. *See* Exhibit 6, incorporated herein. On information and belief, "Mary" refers to Mary Szafranski, who received the list from Freedom with instructions to encourage the listed members to disenroll.

83. In October 2008, Relator witnessed Beverly Parrish having a phone conversation with Mital Panara. After the call, Parrish told Relator that Panara had said he would give her a list of members to move to another health plan, and that he wanted to meet with her personally to discuss payment. Parrish also told Relator that Panara had given her such a list before, near the end of the 2008 open enrollment period. *See* Exhibit 7 (Relator's notes dated 10/08/08), incorporated herein.

84. In rough notes on November 24, 2008, Mital Panara set out his ideas for inducing unhealthy members to leave, including offering financial incentives to sales agents such as Jeff Wood to encourage disenrollments:

> DM List,
>
> . . .
>
> Compare FH [Freedom Health] benefits with other plans.
>
> Call DM list members (by sales agency like Jeff wood) and explain them other plan benefits.
>
> Can we Send them letter with benefits compare.
>
> Invite them on lunch on seminar.

> Delay their membership card and other documents, diabetic supply, OTC [over-the-counter] supply etc.
>
> If PCP [primary care physician] is at risk or good relation. Tell them to move to some other plans.
>
> . . .
>
> More Incentive to DM agents.

Exhibit 8, incorporated herein.

85. By skimming the most unprofitable beneficiaries from its membership rolls, Freedom was able to receive Medicare's adjusted capitation rates without taking on the risk of losses from covering the sickest, most unprofitable beneficiaries. Therefore, Freedom's service costs were artificially low, and its profits artificially high. On information and belief, this fraudulent practice is systemic and ongoing. Meanwhile, Medicare has been deprived of the benefit of its bargain that Freedom take on the risk of covering expensive beneficiaries.

2. Discriminatory Cherry Picking of Special Needs Plan Beneficiaries

86. As Freedom explored ways to grow in early 2008, its management discovered a way to both increase its revenue for existing members and enroll new members outside of Medicare's fixed enrollment windows, the annual election period and open enrollment period. Freedom's plan was to transfer its existing beneficiaries, and enroll new ones, into its two chronic condition SNPs. As discussed above, CMS created the SNP program to improve care for the frailest and most vulnerable Medicare beneficiaries. Because Freedom was preparing bids for new chronic condition SNPs for 2008, the bids Freedom submitted to CMS necessarily used external data, such as figures

from competitors' preexisting SNPs, to estimate its costs and form the bid amount. Because Freedom could not draw on its own past results, its bid was inevitably rough. And as it happened, Freedom ended up receiving a higher capitation rate—over $200 more—for its SNP members compared to its regular MA plan members. For Freedom's managers, this unexpected discrepancy was a strong incentive to grow its new SNPs. Unlike normal MA plans, moreover, there are no enrollment windows for chronic condition SNPs, so Freedom was free to enroll eligible Medicare beneficiaries in them at any time.

87. To Freedom's management, the SNP program was an opportunity to receive higher Medicare payments for free. From early 2008, when Freedom's managers realized its potential, until the present day, Freedom has knowingly misused its SNPs to generate artificial profits at the expense of Medicare and its beneficiaries. It carried on these fraudulent activities in several ways, including without limitation (1) knowingly identifying and disenrolling expensive SNP members, including members that Freedom had previously confirmed as being qualified for the SNP, and (2) knowingly failing to disenroll unqualified or unconfirmed members by CMS deadlines, so that Medicare would continue to pay higher rates for them.

88. To enroll in a SNP, a Medicare beneficiary must have a qualifying condition, such as a severe or disabling chronic disease. The MA organization is responsible for confirming the existence of the qualifying condition with the beneficiary's provider. CMS requires MA organizations to disenroll SNP members whom they find lack a qualifying condition (such as a chronic disease), or whose

condition they are not able to confirm within a certain timeframe. For 2008, MA organizations had until October 1 to confirm their SNP members or, if they could not, notify them of their disenrollment; for 2009, CMS gave MA organizations thirty days to confirm their new enrollees' qualifying conditions, before they would have to disenroll them:

> Previously [in 2008], if the enrollee was accepted into the SNP, but was later determined not to have had the targeted condition . . . , the enrollee would remain in the SNP until the end of the calendar year and would be disenrolled at that time. The MAO must notify the enrollee of this disenrollment by October 1 of each year. . . . For CY 2009, SNPs will be required to disenroll individuals following determination that the individual did not have the targeted condition. The MAO will be required to provide notice of this prospective disenrollment. Disenrollment will be effective the first of the month following the month in which the plan provides the member with notification of disenrollment.

Centers for Medicare & Medicaid Services, 2009 Call Letter for Medicare Advantage Organizations 32–33 (2009).

89. Beyond the narrow task of confirming that a SNP member suffers a qualifying chronic condition, an MA organization may not use health status as a basis for choosing whom to enroll or disenroll. *See* 42 C.F.R. § 422.110(a); 42 C.F.R. § 422.2 (stating that CMS reviews SNP proposals to ensure they do not "discriminate[] against sicker members of the target population"). In its contract, Freedom certified to CMS that it "shall comply with the provisions of § 422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a

CMA-approved [*sic*] special needs plan that exclusively enrolls special needs individuals as consistent with §§ 422.2, 422.4(a)(1)(iv) and 422.52." Exhibit 2.

90. At the beginning of 2008, Freedom's three SNPs accounted for a tiny fraction of its total membership. Freedom's SNPs were the "Medi-Medi" plan, which covers benefits for beneficiaries eligible for both Medicare and Medicaid, the "VIP Care" plan, which covered beneficiaries with chronic conditions with a supposed emphasis on cardiac care, and the "VIP Care+" plan, which also covered chronic condition beneficiaries, but with a focus on diabetes. (Freedom has subsequently renamed the VIP Care+ plan the "VIP Care Savings" plan, and its plans now have different benefit structures instead of different disease focuses.) In March 2008, the Medi-Medi plan had 725 enrollees, the VIP Care plan 57 enrollees, and the VIP Care+ plan 5 enrollees. *See* Exhibit 9, incorporated herein.

91. In or around February 2008, Freedom managers realized that CMS was paying Freedom more for SNP beneficiaries than for regular plan beneficiaries. The managers therefore calculated that they stood to receive over $200 in additional per member per month payments if they moved eligible beneficiaries into the VIP Care plan from their current, general MA plans. With Freedom's general MA plans containing an estimated 8,125 SNP-eligible beneficiaries, extra payments could reach $1.89 million per month. *See* Exhibit 2, incorporated herein. Better yet, Freedom could get this extra revenue without having to wait for the next open enrollment period in November. And as a further incentive, Freedom could market the VIP Care plan year-round, a crucial tool for growth during the months when promoting ordinary MA plans is not allowed.

92. Soon after this, Freedom began moving members out of its general MA plans, and into its SNP plans, at a phenomenal rate. Freedom termed this effort the "VIP Care Project," and it grew the VIP Care plan from 57 enrollees in March 2008 to 5,795 enrollees in August 2008. *See* Exhibit 9. Most of the early converted beneficiaries came from Marion County, where Dr. Pagidipati had strong provider connections that he enlisted to rapidly convert hundreds of members. Freedom closely watched the rate of conversions, tracking the number of enrollees as a percentage of overall eligible members. By December 2008, Freedom had 8,279 beneficiaries enrolled in the VIP Care plan. By 2009, the VIP Care and VIP Care+ plans ranked among the top 10 largest SNPs in the country.

93. Pressure to expand the SNPs came from the top. Mital Panara told Relator and Patricia Petro, Freedom's Case Management Manager, that Dr. Patel had asked him at the beginning of the year to convert at least 4,000 members into the SNPs. According to Panara, Dr. Patel was "very happy" that Panara had exceeded the target by 3,200. Exhibit 10 (Relator's notes dated 10/16/08), incorporated herein.

a. October 2008 Discriminatory Disenrollments

94. Having enrolled as many beneficiaries as it could into its SNPs, Freedom now confronted the task of managing them. Its first test came on October 1, 2008, when it faced a CMS deadline to send disenrollment notices to all members that it had enrolled in the SNP but not yet confirmed. This should have posed a problem for Freedom, as it had confirmed only 1,781 of its more than 7,000 SNP members by October 8. Losing over 5,000 lucrative members was unthinkable to Freedom management, however,

because they needed uninterrupted growth to make Freedom valuable enough to sell on a short timeframe. Therefore, instead of disenrolling all unqualified/unconfirmed SNP members, Freedom's management knowingly engaged in a two-sided scheme to defraud CMS.

95. First, Freedom used the disenrollment deadline as an opportunity to get rid of its least healthy SNP members. On October 20, 2008, Mital Panara and Relator met in Relator's office. Panara told Relator that he wanted to disenroll all expensive members from the SNP, whether they had been confirmed or not. Panara said that disenrolling unconfirmed members was easy, but that disenrolling confirmed members would require him to destroy the members' qualifying forms. Panara said he would remove the qualifying forms from the members' files and burn them, adding (paraphrase) "I do not trust shredding, I burn things."

96. Mital Panara, a finance expert with no medical background, then asked Relator how to predict if a member with high costs in the present year would be profitable in the next. Relator is not normally involved in Freedom's enrollment decisions; Panara was approaching him because of his medical knowledge. Relator explained to Panara that members with multiple hospitalizations usually continue to be unprofitable, while members with a single hospitalization are more likely to become profitable, as they are often healthy patients who had suffered an isolated illness. From this, Panara concluded that Freedom should disenroll SNP members with multiple hospitalizations. Exhibit 11 (Relator's notes dated 10/20/08), incorporated herein.

97. The next day at about 3:20 p.m., there was a meeting between Relator, Mital Panara, and Sidd Pagidipati. Relator had called the meeting to discuss the changes Freedom had to make to comply with the October 1st deadline for qualifying SNP members. Sidd asked what Freedom needed to do about the issue. Panara replied that Freedom should be disenrolling the unqualified SNP members, and that it would do so, but only for the most expensive members. Panara told Sidd he would compile a list of members with four or more hospitalizations and over $10,000 in claims, and disenroll them. Panara also told Sidd that Freedom only had one copy of qualified members' confirmation forms, and that he would make those forms disappear. Sidd responded "good work" and instructed Panara to "move forward" with this plan. Panara said he would have a disenrollment list ready for Sidd in the next day or two. Relator had been working with IT on a report of high-cost members to use for case management stratification, and Panara asked Relator to forward it to him so he could use it to identify members with more than four hospitalizations. Exhibit 12 (Relator's notes dated 10/21/08), incorporated herein.

98. Immediately after the meeting, at 3:44 p.m., Relator sent an email to Freedom's data managers, copying Mital Panara, repeating his request for an updated version of Freedom's 2008 expenses data. At 4:27 p.m., a Freedom data employee sent an email to Relator and Panara with a spreadsheet of Freedom's 2008 expenses attached. *See* Exhibit 13, incorporated herein.

99. At about 4:50 p.m., Mital Panara came to Relator's office and began sorting the 2008 expenses spreadsheet. Panara isolated SNP members with four or more

hospitalizations, and also picked out three SNP members with no hospitalizations but high claims costs, so that CMS would be less likely to spot a pattern. Relator asked Panara to email him the sorted spreadsheet, and said he would email Panara the 2007 and 2008 Medicare Call Letters, so that Panara could find the appropriate disenrollment letter to send to the members. Panara then said he would get final approval from Sidd to go ahead with the disenrollment. Exhibit 14 (Relator's notes dated 10/21/08), incorporated herein. After this meeting, at 5:16 p.m., Relator emailed the Call Letters to Panara, and at 5:37 p.m. Panara replied to Relator's email, with the sorted spreadsheet attached, showing the 51 members Panara intended to disenroll. Exhibit 15, incorporated herein.

100. The 51 beneficiaries Mital Panara targeted included both beneficiaries whom Freedom had confirmed as being SNP qualified, and beneficiaries whom Freedom had not yet confirmed. Panara understood that his and Sidd's plan would disenroll confirmed SNP members, as he created a spreadsheet on October 23 that listed only the 31 confirmed target beneficiaries. Exhibit 16, incorporated herein.

101. Freedom's Enrollment Department received the list of 51 targeted beneficiaries, and sent each a disenrollment letter on October 29. Exhibit 17 (Enrollment Department's disenrollment list), incorporated herein. When Freedom discovered a typo in the letters it had mailed, it sent out a corrected batch on October 31. Exhibit 18 (representative disenrollment letter), incorporated herein. America Young, an enrollment department employee, was in charge of sending out the disenrollment letters.

102. Knowing that Mital Panara would destroy the qualification documents for the confirmed SNP members on Freedom's disenrollment list, Relator went to the

members' files and made copies of thirteen members' qualification letters. Exhibit 19. Sure enough, when Relator asked Panara about the files on October 27, Panara said he "had taken care of them," and Relator later spotted the files on Panara's desk. Exhibit 20 (Relator's notes dated 10/27/08), incorporated herein. On October 29, Relator checked the files for several confirmed members, and saw that their qualification letters were gone, just as Panara had said they would be. Exhibit 21 (Relator's notes dated 10/29/08), incorporated herein.

103. Freedom sent disenrollment letters to the 51 beneficiaries, denying that they suffered a chronic condition that would qualify them for the SNP. In response, some beneficiaries complained, calling and sending letters attesting to their serious and chronic health conditions. *See* Exhibit 22, incorporated herein. Others did not respond, and were disenrolled on December 31, 2008. Exhibit 23, incorporated herein. Some of these members later re-enrolled, while others never came back. Though Freedom did not succeed in getting rid of all 51, it still benefited from its scheme. Relator spoke with Mital Panara on November 3 about complaints Freedom had received from targeted beneficiaries who wanted to stay on its plans. Panara said that even if only half stayed off Freedom's plans, Freedom would still come out ahead, because it would still be losing unprofitable beneficiaries. Exhibit 24 (Relator's notes dated 11/03/08), incorporated herein. Notably, America Young instructed Freedom's enrollment employees to give her the complaint letters Freedom received from targeted beneficiaries, saying she was "handling these letters for [a] special project from Mital." Exhibit 25, incorporated herein.

104. On November 24, 2008, Mital Panara wrote down how Freedom was perversely using the SNP enrollment process to disenroll undesirable members. In rough notes, Panara wrote that Freedom could get rid of its high-cost members by moving them into the chronic condition SNP, and then not seeking qualification from their doctors: "Convert them to VIP and disenroll because of chronic condition not verified by PCP [primary care physician]." Exhibit 8, incorporated herein.

105. In October 2008, Freedom identified 51 of its frailest members—the very ones whom the SNP program is supposed to serve—and sent them disenrollment letters because of their poor health status. Had CMS known of this, it could not have continued to contract with Freedom. By continuing to contract with CMS after October 2008, and by certifying in those contracts that it did not discriminate by health status (as discussed in ¶77), Freedom knowingly and fraudulently induced false payments from CMS.

b. March 2009 Discriminatory Disenrollments

106. The next major enrollment event Freedom faced was the end of the 2009 CMS open enrollment period, on March 31, 2009. Just as it had in October, Freedom used this deadline as an opportunity to disenroll expensive members.

107. By March 3, 2009, Freedom knew it had approximately 2,500 unqualified members in its SNPs, and that it would have to disenroll them by the end of the month. In a meeting in Sidd Pagidipati's office between Sidd, Mital Panara, and Relator, Sidd told Panara to disenroll the unqualified SNP members, but to mix in high-cost "dogs" at a 1:1 ratio, so as to intersperse the expensive beneficiaries with those Freedom was

supposed to disenroll, and thus keep CMS from suspecting anything. Exhibit 26 (Relator's notes dated 03/03/09).

108. On March 20, Mital Panara told Relator that he wanted to use data from Freedom's Health Assessment Tool ("HAT") to identify unconfirmed beneficiaries with multiple hospitalizations. Panara said that even if just 10–20 of the approximately 900 unconfirmed SNP members had multiple hospitalizations, disenrolling them could save Freedom "a couple of million dollars." Exhibit 27 (Relator's notes dated 03/20/09). As in October, Panara said he would have to go over the plan with Sidd.

109. The HAT is a form Freedom sent to beneficiaries to fill out their own health history, including past hospitalizations. Mital Panara used the HAT data to identify unconfirmed beneficiaries with 2–3 hospitalizations. From a separate list, Panara identified beneficiaries with high claims histories, and added these high-claim members to the list he had created from the HAT data. Panara had settled on a formula for targeted disenrollment: eliminate patients with 2–3 hospitalizations and a high MLR value. In total, Panara singled out 47 sick, unprofitable beneficiaries whom he wanted to disenroll. He saved his work product in a spreadsheet, titled "Sidd—VIP Care Not Verified," with separate worksheets for the HAT and claims lists, and a final worksheet showing the 926 unconfirmed SNP members, with the 47 targets listed prominently at the top. Exhibit 28, incorporated herein.

110. Mital Panara told Relator that he would remove the 47 targeted beneficiaries from Freedom's list of the SNP members who needed to be confirmed. At the time, Freedom was scrambling to confirm hundreds, if not thousands, of its SNP

members. The enrollment and provider relations ("PR") departments were busy contacting beneficiaries and their doctors, reminding them to send qualifying forms. By removing the 47 targeted beneficiaries from the Enrollment and PR lists, Panara hoped to decrease the odds that they would turn in their forms. Exhibit 29 (Relator's notes dated 03/23/09), incorporated herein.

111. On March 26, Mital Panara created on his computer a spreadsheet titled "VIP Yet to Verify—PR" containing a "Final after DM" worksheet that did not include the 47 targeted beneficiaries. Exhibit 30, incorporated herein. The same day, Panara created two spreadsheets titled "VIP Yet to Verify—Sean" and "VIP Yet to Verify—Sean v2." The first contained two worksheets, "DM" and "After DM." The "DM" worksheet included 42 of the 47 targeted beneficiaries (five having been confirmed in the interim). The "After DM" worksheet was the same as "DM," but with the 42 targets removed. Exhibit 31, incorporated herein. The spreadsheet "VIP Yet to Verify—Sean v2" contained a single unlabelled worksheet identical to the "After DM" list, showing that Panara had repackaged the "Sean" spreadsheet to hide his efforts. Exhibit 32. On Relator's information and belief, "Sean" refers to Sean O'Sullivan, an employee of the vendor that runs Freedom's call center, who would have been conducting Freedom's campaign to call members and remind them to send qualifying forms.

112. The deadline for qualifying SNP enrollees was March 31, and Freedom had to notify the unqualified beneficiaries of their disenrollment by April 6. By the time Freedom sent disenrollment letters on April 6, approximately 26 of the 42 targeted beneficiaries were still unconfirmed, the others having sent in their qualifying forms.

When the April disenrollment became final, Freedom had removed 19 of the beneficiaries it had selectively not tried to confirm.

113. Relator spoke with Mital Panara on May 26, 2009 about the SNP disenrollment. Panara told Relator that Dr. Patel and Rupesh Shah, a former WellCare executive who, despite an active non-compete agreement, was working as a senior advisor to Freedom, both knew about the effort to disenroll expensive SNP members. When Relator noted his surprise at Dr. Patel and Shah's involvement in the fraud, Panara said that they "are very smart men and are involved in everything." Exhibit 33 (Relator's notes dated 05/26/09), incorporated herein.

114. Unlike the October 2008 disenrollment, Freedom did not try to disenroll confirmed SNP members in April 2009, a decision that reflected its growing concern about increased scrutiny, and an upcoming audit, from CMS. During his May 26 conversation with Relator, Panara said that Dr. Patel and Rupesh Shah had decided to try to qualify each new April 2009 enrollee, and not to discriminate against the unhealthy ones. Panara said that Shah had said that Freedom was a big plan now, and that it could not disenroll sick members unless it understood its operations and executed its scheme perfectly. According to Panara, Shah said that once Freedom better understood CMS enrollment procedures, it could resume its discriminatory enrollment scheme with the May 2009 and subsequent enrollees. Exhibit 33.

c. Retaining Beneficiaries who were Unconfirmed, but Profitable

115. Removing expensive members from its SNPs was just one half of Freedom's plan to defraud Medicare. At the same time it was using CMS involuntary

disenrollment deadlines to skim high-cost members, Freedom was consciously ignoring those same deadlines as they applied to hundreds of unconfirmed Freedom SNP members whom Freedom was supposed to disenroll.

116. As Freedom rushed to enroll beneficiaries into the SNPs during 2008, it made little effort to confirm beneficiaries after it enrolled them. Consequently, unconfirmed SNP members far outnumbered the confirmed ones, as described in ¶94. CMS guidance required Freedom to confirm or send disenrollment notices to all unconfirmed SNP members by October 1, 2008. *See* Centers for Medicare & Medicaid Services, 2009 Call Letter for Medicare Advantage Organizations 32–33 (2009). With thousands of unconfirmed members, Freedom knew it had little chance of confirming everyone.

117. Yet Freedom had no intention of disenrolling all of its hundreds of unconfirmed SNP members, as CMS regulations mandated. As discussed in ¶¶69–71, Freedom's managers were on a tight schedule to grow the company and sell it, and extracting as much profit as possible from the SNPs was at the heart of their strategy. Forced to choose between their growth targets and compliance, Freedom chose growth.

118. On October 5, 2008, four days after the October 1 deadline to send disenrollment notices to unconfirmed SNP members, Relator met with Mital Panara and Patricia Petro, Freedom's Case Management Manager, to discuss the SNP program. Panara told Relator and Petro that the SNP team was not qualifying beneficiaries before they enrolled in the SNP, and that he knew Freedom was required to disenroll its approximately 5,200 unconfirmed SNP members, but would not. When Relator told

Panara that Freedom needed to disenroll those members, Panara laughed. Exhibit 34 (Relator's notes dated 10/05/08), incorporated herein.

119. On October 13, 2008, in a meeting with Sidd Pagidipati and Mital Panara, Relator again brought up the confirmation issue. When Sidd asked Panara how long it would take to qualify everyone in the SNP, Panara said he could get "a good number" qualified by the end of the year, but not all. Exhibit 35. In a meeting on October 16, Relator told Panara that Freedom should send disenrollment letters to the 4,200 unconfirmed SNP members, to which Panara replied that he would not do so, because he was still trying to qualify them.

120. As might have been expected, Freedom came nowhere near to qualifying every unconfirmed SNP member by the deadline. A comparison of a July 2008 SNP enrollment list and a December 2008 list of unconfirmed SNP members shows that 773 beneficiaries who were enrolled in the SNP in July were still unconfirmed in December, two months after the October 1, 2008 deadline. Exhibit 36, incorporated herein.

121. As discussed in ¶¶94–105, Freedom management decided to disenroll a small number (51) of unprofitable SNP members on October 31, 2008, rather than the hundreds of more profitable beneficiaries who were still unconfirmed. By purposely not disenrolling members who were unqualified for the SNP, Freedom directly and falsely induced CMS to make payments to it for these members, who should not have remained on Freedom's plans, at $100–200 a month above the non-SNP monthly capitation rate.

122. The direction to keep unqualified members in the SNPs came from the top. On December 9, 2008, Mital Panara told Relator that he would continue to hold on

to unconfirmed members beyond CMS deadlines in the next year, because Dr. Patel and Sidd Pagidipati had told him that Freedom needed the revenue. Exhibit 37 (Relator's notes dated 12/09/08), incorporated herein.

123. Beginning in January 2009, CMS regulations required Freedom to qualify SNP members within thirty days of enrollment. Pressured for more revenue, however, Freedom ignored this new disenrollment rule. Freedom had 4,316 beneficiaries who enrolled in the VIP Care and VIP Care+ plans effective January 1, 2009, making them subject to the thirty-day qualification requirement. Exhibit 38, incorporated herein. Of these 4,316, 451 were still unconfirmed on March 5. Exhibit 39, incorporated herein. Moreover, 181 of the 451 were beneficiaries Freedom had enrolled in *July 2008*, as discussed herein at ¶120. On March 30, another Freedom list shows that of its 925 unconfirmed SNP members, 543 had been enrolled as of January 2009, clearly establishing that they were overdue for disenrollment. Exhibit 40, incorporated herein. Freedom had made little effort to comply from the start, only sending the January enrollees' confirmation forms to providers on January 22, 2009—leaving just six business days before the confirmation deadline for the providers to review, sign, and return all 4,316 forms, something that unsurprisingly did not happen.

124. These oversights were not accidental, but rather were part of Freedom's continuing efforts to defraud CMS. On December 9, 2008, as discussed herein at ¶122, Mital Panara told Relator that he planned to not disenroll unconfirmed SNP members in the coming year. On January 9, 2009, Pradeep Kathi, Freedom's Compliance Officer, told Relator that he knew about the thirty-day qualification requirement, and that he

would talk to Sidd Pagidipati about it. Exhibit 41 (Relator's notes dated 01/09/09), incorporated herein. On February 9, 2009, Relator emailed Sidd to warn him of the looming deadline for disenrolling January enrollees, to which Sidd responded "[e]nrollment is working with compliance on a corrective action plan for January and February enrollments." Exhibit 42, incorporated herein. Given that Freedom still had fourteen business days to qualify its February enrollees, its preparation of a corrective action plan for them suggests that Freedom did not intend to qualify or disenroll them compliantly, but instead was preparing an excuse in case CMS noticed. On February 11, 2009, Relator spoke with Panara and reminded him of the disenrollment deadline, to which Panara laughed and said Freedom "was not going to do that." Exhibit 43 (Relator's notes dated 02/11/09), incorporated herein.

125. That same day, February 11, 2009, Freedom Compliance Officer Pradeep Kathi warned Sidd Pagidipati that Freedom was noncompliant in its SNP enrollment practices:

> If we are audited now, we will fail the following audit elements . . . :
>
> (1) Enrollment—delays in upload of forms to CMS, delays in sending out required member letters, not acting on member calls requesting cancellation/disenrollment
> (2) Delays in SNP member confirmation of chronic condition
> (3) Not following in Ch 2 timelines on disenrollment of SNP members
> . . .

Exhibit 44, incorporated herein.

126. Except for the October 31, 2008 selective disenrollment of 51 expensive SNP members, the first time Freedom disenrolled its unconfirmed SNP members—those from 2008 and 2009—was in April 2009. This was the direct result of two related factors. First, Freedom felt it had to become compliant by the end of the open enrollment period on March 31, when it would become harder to move beneficiaries to other Freedom plans. Second, Freedom knew that its dramatically enlarged SNPs, now ranking in the top ten nationally by enrollment, would increase the likelihood of CMS scrutiny/auditing.

127. For at least the prior six months, however, Freedom had knowingly and fraudulently filled its SNPs with hundreds and sometimes thousands of unqualified beneficiaries. Every month, CMS paid Freedom inflated SNP rates for these members, who had no business being in the SNPs, or in Freedom plans at all, because disenrolled beneficiaries revert into traditional Medicare by default. Had CMS known about Freedom's fraudulent enrollment practices, it would not, and indeed could not, have made those payments.

3. Selective Removal of Expensive Members from Retention Mailings Sent to Patients of Terminated Providers

128. Whenever a health care provider leaves Freedom's network, it creates an opportunity for Freedom to discriminate against its sick/unprofitable beneficiaries. Following a termination, Freedom and the provider compete to hold onto the provider's patients, who, if they stay with the provider, will leave Freedom's plan. Freedom, however, cherry picks the patients it tries to retain, through selective marketing. The departing provider's healthier patients receive letters and phone calls from Freedom,

notifying them of the termination and urging them to switch to a new provider in Freedom's network, while the provider's sick, expensive patients receive no contact from Freedom.

129. This practice squarely violates federal regulations. MA organizations cannot pick and choose which beneficiaries they wish to notify about a termination:

> The MA organization must make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must be notified.

42 C.F.R. § 422.111(e). And, of course, MA organizations may not discriminate on the basis of health in their enrollment activity, *see* 42 C.F.R. § 110(a), a basic principle that Freedom certified to CMS it would comply with. *See supra* ¶77.

130. Around February 2009, three primary care providers left Freedom's provider network: Healthcare America ("HCA"), Morton Plant Mease Primary Care ("Morton Plant"), and Dr. Augustin Ferreiro ("Dr. Ferreiro").

131. On February 4, 2009, Mital Panara identified the least profitable HCA patients. Panara created a spreadsheet listing HCA's 1,180 Freedom beneficiaries. He then separated the patients into two groups, one for the unprofitable members Freedom would not try to retain, and one for the more profitable members it would try to retain. Panara expressed this dichotomy by color: the 121 expensive patients were colored red, and the 1,059 inexpensive patients green. Exhibit 45, incorporated herein.

132. Freedom repeated this process six days later for Morton Plant's patients. In a spreadsheet, Mital Panara created a worksheet with a red list of 135 expensive "DM" patients. A second worksheet contained the 1,336 "Total" number of Morton Plant patients, using the DM worksheet to identify which were DM patients. The third, "Final" worksheet contained 1,193 patients, which comprised the total Morton Plant patient list minus the DM patients. Exhibit 46, incorporated herein.

133. Freedom then identified the costly patients of Dr. Ferreiro. Like with HCA and Morton Plant, Panara identified the 112 active Freedom beneficiaries who were patients of Dr. Ferreiro. Panara then created a new list, seemingly the same as the first, but with the 15 costliest beneficiaries by MLR replaced with 15 new beneficiaries. In effect, Freedom had swapped out the most expensive beneficiaries from its retention list for Dr. Ferreiro. Exhibit 47, incorporated herein.

134. Having filtered out the sick/unprofitable members, Mital Panara passed the adulterated patient lists on to Freedom provider representatives, so they could begin the retention effort. On information and belief, the same day Panara identified the unprofitable Morton Plant patients as discussed in ¶132, he gave a list containing just the 1,193 inexpensive Morton Plant patients to Chris Curtis, a Freedom Provider Operations Representative. Exhibit 48, incorporated herein.

135. Likewise, on February 16, 2009, Mital Panara created a spreadsheet titled "HCA & Morton Plant for Rakesh" with two worksheets. Sheet1 contained the 1,059 inexpensive HCA patients and Sheet2 the 1,193 cheap Morton Plant patients. Exhibit 49, incorporated herein. The spreadsheet accounted for none of the unprofitable HCA or

Morton Plant beneficiaries. On information and belief, Panara gave this spreadsheet to Rakesh Shah, Freedom's Information Systems Project Manager, who is responsible for processing the mailings that Freedom sends to its members.

136. Freedom only mailed retention packets to the healthy/profitable members Mital Panara had identified. On February 18, 2009, Rakesh Shah emailed DeeAnn Garey-Roy, then Freedom's Provider Representative for Manatee County, to report on the number of mailings Freedom had sent:

> DeeAnn,
>
> We printed 1350 kits and we mailed out 1174 (1060 for Manatee and 114 for Ferreiro) so we have balance of about 176 kits
>
> Let us know what you need to with those kits
>
> Thanks
>
> Rakesh

Exhibit 50, incorporated herein. By "Manatee," Shah was referring to HCA. The number of mailings for HCA patients corresponds closely to Freedom's list of profitable HCA patients, discussed above in ¶131.

137. To improve the odds that the unprofitable patients would leave Freedom, Mital Panara listed all of the costly HCA and Morton Plant patients Freedom wanted to lose—121 for HCA and 135 for Morton Plant—and had it given to independent sales broker Mary Szafranski so she could encourage the patients to move to other health plans. Exhibit 51, incorporated herein. Panara created the list on February 13, 2009, and gave it to Relator with instructions to pass it on to Szafranski. On February 23, Panara

asked Relator if he had given the list to Szafranski. Exhibit 52 (Relator's notes dated 02/23/09), incorporated herein.

138. Freedom closely tracked its success at retaining beneficiaries. For HCA, Freedom recorded how many beneficiaries had changed to Freedom primary care physicians, how many were staying with HCA, and how many were still undecided. For every beneficiary who switched providers, Freedom recorded which representative had persuaded the beneficiary to do so. However, the retention list Freedom was using to keep these members excluded HCA's sick and costly patients. Exhibit 53, incorporated herein. Indeed, the list had come from Mital Panara, and thus contained only the approximately 1,050 healthy HCA patients.

139. Relator discovered Freedom's discriminatory retention activities by talking with DeeAnn Garey-Roy, then Freedom's Provider Representative for Manatee County. In a February 19, 2009 phone call, Garey-Roy told Relator that Freedom was giving member lists for terminated providers to Mital Panara, who was reviewing the lists and removing the costly patients. Garey-Roy estimated that Panara was removing 10% of members. Freedom was then mailing the remaining members a packet explaining how to switch to a participating provider in Freedom's network, and was also sending their names to customer service for follow-up phone calls. Exhibit 54 (Relators notes dated 02/19/09), incorporated herein.

140. Soon after the call, Garey-Roy emailed Relator the team report for the HCA retention project, discussed in ¶138, and revealed that Mital Panara, whose finance

job belies his role as Freedom's bag man for illicit projects, had supplied the retention list:

> Gabe's team report is attached on the HCA member reach out program. Tab B has the list provided by Mital. They had a total of 1147 members. Dr. Ferreiro had 130 members. I believe that we sent out about 113 letters to his membership. I don't have that list though. Perhaps Mital could get that to you?

Exhibit 55, incorporated herein. When Relator asked Garey-Roy to explain why Freedom had not sent mailings to every HCA and Dr. Ferreiro patient, Garey-Roy said "I think we addressed that in our discussion as to my theory [*see* ¶139]; but why would you want me to put that in writing?" Exhibit 55.

141. On information and belief, Freedom has engaged in a similar pattern of fraud for other terminated providers, including without limitation nine Pinellas County providers whom Freedom terminated around the same time as Morton Plant.

142. By identifying the least healthy, most unprofitable beneficiaries in terminated provider groups, and then omitting them from Freedom's retention efforts, Freedom violated federal law and defrauded Medicare.

4. Fraudulent Omission of High-Cost Patients during the CMS Reconciliation Process.

143. On January 1, 2008, as Freedom rolled over its Medi-Medi plan from 2007 to 2008, an enrollment error occurred. A subset of the beneficiaries who had been in Freedom's 2007 Medi-Medi plan were supposed to transition to the 2008 plan, but instead were disenrolled from the Freedom Medi-Medi plans, reverting to original Medicare insurance. Upon discovering this mistake in early June 2008, Freedom was

able to recover some of the erroneously disenrolled beneficiaries by re-enrolling them effective May 1, 2008. Freedom then sought to recover the revenue that Freedom had lost during the five-month period when the members were mistakenly disenrolled. Munaf Kapadia, Freedom's Vice President of Enrollment, submitted a payment adjustment request to Integriguard LLC ("Integriguard"), a contractor that manages retroactive payments for CMS. The request asked Integriguard to retroactively enroll the beneficiaries in the Medi-Medi plan effective January 1, 2008—the date they were mistakenly disenrolled. Because the beneficiaries had reverted to regular Medicare in January, CMS owed Freedom the revenue it should have been paid for the beneficiaries from January to April, and Freedom owed CMS for any claims it had paid for the beneficiaries during that same time. Therefore, Integriguard was to total all revenue due to Freedom, deduct all claims CMS had paid from January to April, and pay Freedom the difference.

144. CMS has a fixed process for reconciling payments arising from enrollment mistakes. Every week, CMS sends MA organizations a Transaction Reply Report ("TRR"), summarizing the organizations' weekly enrollment activity. Once a month, each MA organization must reconcile the TRRs it has received, which reflect what CMS understands the MA organization's membership to be, with its own records and, if there are any discrepancies, request an enrollment adjustment. The adjustment request goes to Integriguard for analysis. If it is proper, Integriguard validates the change and enters it into the CMS records system. CMS will then account for the change in its next Plan Payment Report ("PPR"), which calculates its payments to the MA

organization. As discussed in ¶143, if a beneficiary has been mistakenly disenrolled, CMS credits the MA organization for the months when the beneficiary was not on the plan and deducts any medical expenses it covered during that same time.

145. After Munaf Kapadia submitted the reconciliation request to Integriguard for the 2007 Medi-Medi members, Freedom discovered that one of the affected beneficiaries had undergone a heart transplant during the time he had been mistakenly disenrolled. The beneficiary (hereinafter "transplant patient") enrolled in the Medi-Medi plan in November 2007, and was accidentally disenrolled on January 1, 2008. Exhibit 56, incorporated herein. On April 17, 2008, the transplant patient was admitted to Tampa General Hospital ("Tampa General"), and underwent a heart transplant on May 5, 2008. Exhibit 57, incorporated herein. The total charge for Tampa General's services was $1.15 million, and Tampa General invoiced Freedom's Claims Department for the full amount. Exhibit 58. The amount Freedom was contractually required to pay (i.e., the allowable amount) for Tampa General's invoice was approximately $250,000.

146. Not yet knowing about the transplant, Freedom re-enrolled the transplant patient on June 9, 2008, effective back to May 1, 2008, as part of the reenrollment process for the erroneously disenrolled 2007 Medi-Medi members. It then placed the transplant patient on the Integriguard adjustment list on June 17, 2008, so that CMS would retroactively enroll the patient back to January 1, 2008. Exhibit 59. Freedom did this so it would receive monthly revenue for the transplant patient from January to April. On June 30, 2008, Freedom submitted a "retro packet" to Integriguard for all of the affected 2007 Medi-Medi members, including the transplant patient.

147. Freedom received Tampa General's invoice for the transplant patient on July 9, 2008, and entered the claim into its system on July 11. Because Freedom had re-enrolled the transplant patient effective May 1, 2008, it was responsible for covering the Part B services, such as doctor's rounds, which the patient had received in May, because Part B coverage depends on the date of the service, and the transplant patient became Freedom's responsibility on May 1. Relator estimates these costs to be little more than $15,000—a pittance compared to Tampa General's total bill. By contrast, Freedom was not yet visibly responsible for covering the transplant patient's much more expensive Part A benefits, such as the hospital stay and the heart transplant itself, because Part A coverage is determined by when the patient entered the hospital, and the patient here was admitted in April. Freedom was also not yet visibly responsible for Part B services rendered before May 1. But the reconciliation request, which Freedom had already submitted, stood to move the transplant patient's enrollment date back to January 1, making Freedom clearly responsible for *all* Part A and Part B services, and thus the entire allowable of approximately $250,000.

148. To keep Freedom from paying a $250,000 claim it knew it was responsible for, Sidd Pagidipati ordered Munaf Kapadia to cancel the reconciliation request for the transplant patient only, but not for any of the other, less expensive 2007 Medi-Medi members. On July 31, 2008, Kapadia emailed Sidd: "Retro packet was submitted to IG [Integriguard] (6/30), I have call in to them to find out how to rescind." Sidd replied, "Make it happen!!!!" Exhibit 60, incorporated herein.

149. On Friday, August 8, 2008, Freedom's Enrollment Department recorded Integriguard's final disposition: "The request for a retroactive change was cancelled. The organization requested that the initial request be disregarded." Exhibit 59. The next business day, August 11, Freedom processed Tampa General's invoice, and denied every procedure as "not authorized." Exhibit 58. By cancelling the reconciliation request for the transplant patient and rejecting Tampa General's invoice, therefore, Freedom concealed from CMS that Freedom was responsible for paying Tampa General's claim.

150. As a direct result of Freedom's fraudulent conduct, Tampa General sought payment from CMS to cover the transplant patient's benefits, and CMS paid the entire claim for Part A services at the amount it was contractually required to pay: $202,548.38. CMS later billed Freedom for the patient's May 2008 Part B benefits, worth only about $15,000, because the patient had a May 1 effective date. Exhibit 61, incorporated herein. Because of Freedom's deliberate concealment, however, CMS has not sought payment from Freedom for the bulk of the approximately $250,000 claim, consisting of Part A benefits ($202,548.48) and April 2008 Part B benefits. Nor has Freedom paid CMS for these benefits on its own accord.

151. Through the acts described above, Freedom knowingly made a false record and/or statement material to its obligation to pay over $200,000 to the Government, and knowingly concealed and improperly avoided its obligation to pay that same sum to the Government.

152. On Relator's information and belief, Freedom's cancelling reconciliation of the transplant patient's claims is part of a larger, ongoing practice of reviewing errors

in the TRR for their financial cost to Freedom and selectively pursuing reconciliation only when it stands to be profitable. On May 26, 2009, Freedom's Enrollment Manager Maria Cardona told Relator that she discusses all TRR issues with Sidd Pagidipati. Cardona said that Sidd will send TRRs to Mital Panara, a business analyst. Exhibit 62 (Relator's notes dated 05/26/09), incorporated herein. Panara lacks medical and enrollment knowledge; Sidd is sending him enrollment errors so he can analyze the beneficiaries' cost. Freedom therefore keeps the inexpensive beneficiaries, and returns expensive ones to CMS or elsewhere. Relator believes Freedom reviews 5–10 TRR errors this way every month and selectively chooses not to reconcile the expensive beneficiaries.

B. Fraudulent Inducement of CMS into Approving Freedom's Applications to Operate Special Needs Plans and to Expand its Service Area

153. Freedom has fraudulently induced CMS into approving its applications to operate special needs plans ("SNP") and to expand its service area. Freedom's fraudulent inducement has included, without limitation, (1) falsely representing to CMS that Freedom would operate its SNPs in accordance with federal regulations and pursuant to the terms of Freedom's SNP applications, and (2) representing to CMS in its service area expansion application that Freedom had contracted with a network of health care providers to serve beneficiaries in the expansion areas, when Freedom did not intend to utilize that network due to its high rates, and ultimately did not include the network's providers in its published provider list, thereby making them invisible—and unavailable—to its beneficiaries once CMS had approved expansion.

1. Non-Compliance With CMS Regulations for Operating a SNP

154. The Medicare Modernization Act ("MMA") allows MA organizations to offer specialized MA plans, known now as SNPs, which limit their enrollment to individuals with special needs. The MMA defines a "special needs" individual as one who is institutionalized, eligible for both Medicare and Medicaid, or has a severe or disabling chronic condition. By targeting special needs individuals, the MA organization can tailor care to address the unique needs of SNP beneficiaries.

155. From its inception in 2003, the SNP program requires CMS to ensure that a SNP meets Medicare Advantage SNP requirements, "as determined on a case-by-case basis, using criteria that include the appropriateness of the target population, the existence of clinical programs or special expertise to serve the target population, and whether the proposal discriminates against sicker members of the target population." 42 C.F.R. § 422.2.

156. One basic service a SNP must provide is to establish a model of care by which it will coordinate care for its beneficiaries. Starting in 2008, CMS required SNPs to provide the following:

> The model of care is, in essence, the system of care which reflects (1) pertinent clinical expertise and the staff structures; (2) the types of benefits; and; (3) processes of care (organized under protocols) that will be used to meet the goals and objectives of the SNP. The model of care should be specific enough to imply what process and outcome measures could be used by the SNP to determine if the structures and processes of care are having an intended effect on the target population.

Centers for Medicare & Medicaid Services, 2008 Call Letter for Medicare Advantage Organizations 45 (2008). The protocols, through which the SNP coordinates care, should

guide the frequency and nature of beneficiary assessments, as well as case management ("CM"), and disease management ("DM"). *Id.*

157. In July of 2008, Congress amended the MMA to specify that a SNP must provide its members with a model of care, supported by an appropriate provider network, that provides specific, individualized CM to its members:

> [S]pecialized MA plan[s] for special needs individuals [must] (A) have in place an evidenced-based model of care with appropriate networks of providers and specialists; and (B) with respect to each individual enrolled in the plan—(i) conduct an initial assessment and an annual reassessment of the individual's physical, psychological, and functional needs; (ii) develop a plan, in consultation with the individual as feasible, that identifies goals and objectives, including measurable outcomes as well as specific services and benefits to be provided; and (iii) use an interdisciplinary care team in the management of care.

42 U.S.C. § 1395w-28(f)(5); 42 C.F.R. § 422.101(f)(1) (effective Sept. 18, 2008).

158. Effective March 13, 2009, CMS further clarified model of care requirements:

> MA organizations offering SNPs must also develop and implement the following model of care components to assure an effective management structure: (i) Target one of the three SNP populations . . . . (ii) Have appropriate staff (employed, contracted, or non-contracted) trained on the SNP plan model of care to coordinate and/or deliver all services and benefits. (iii) Coordinate the delivery of care across healthcare settings, providers, and services to assure continuity of care. (iv) Coordinate the delivery of specialized benefits and services that meet the needs of the most vulnerable beneficiaries among the three target special needs populations . . . , including frail/disabled beneficiaries and beneficiaries near the end of life. (v) Coordinate communication among plan personnel, providers, and beneficiaries.

74 Fed. Reg. 1,541 (Jan. 12, 2009).

159. The CMS SNP program is a pilot program that evolves as CMS gains experience with it. SNP regulations and guidance have been limited, with strict new rules only scheduled to come into effect in 2010. Until then, many contours of a SNP plan have been left to the MA organization's discretion.

160. Freedom exploited this fluid environment, however, by fraudulently managing two SNPs that provided nothing beyond what their ordinary MA plans already offered. While CMS continues to refine model of care standards, it has always required some established system for utilizing staff, benefits, and care processes to achieve SNP objectives. Freedom enacted no such system. It had no models of care, implemented no protocols for coordinating how its providers delivered care, failed to conduct basic nursing contacts, such as an initial phone call to new enrollees to ascertain their needs and goals, and provided critical CM/DM to just 1% of its members. Even if it had created such a system, Freedom lacked the staff to implement it, a deficiency that continues to this day. That Freedom provided so little so soon after executing its contracts with CMS shows that it never intended to comply with federal law, a conclusion that Freedom employees have admitted forthrightly (*see* ¶172).

161. Freedom had no model of care for coordinating delivery of health services to SNP beneficiaries in 2008 and much of 2009. Once it had enrolled a beneficiary into the SNP using a pre-qualification form, Freedom had no system for managing that beneficiary's care, setting health outcome goals, or monitoring if the beneficiary's care was helping to achieve those goals. What Freedom provided, therefore, was nothing

more than traditional MA benefits. By merely paying for services, Freedom deprived its beneficiaries of the benefits of being in a SNP plan. Indeed, without models of care, Freedom's "SNPs" were not really SNPs.

162. Similarly, Freedom established no protocols for determining which beneficiaries required nursing assessments and CM/DM, or how frequently such services were needed. As a result, Freedom performed assessments and CM/DM on a minimal basis. Freedom provided CM/DM to beneficiaries with multiple hospitalizations, those that happened to call and request services, and those with non-healing wounds, such as diabetic wounds and bedsores. The number of Freedom members who received CM/DM has always been woefully small, accounting for only several hundred out of Freedom's thousands of SNP members. For the vast majority, Freedom never performed even a basic initial phone call to determine if CM/DM were needed or wanted, and consequently did not provide CM/DM or anything else.

163. Linda Ward laid bare the artifice of Freedom's SNP program in an email to Sidd Pagidipati on June 15, 2009. Dr. Pariksith Singh, a physician and co-owner of PrimeCare, a large independent practice association, had emailed Sidd on June 13 to ask about Freedom's disease management protocols, which Dr. Singh hoped to harmonize with PrimeCare's operations:

> What kind of Disease Management plans do you have in place for the SNPs?
>
> Can you send me the protocols please?
>
> I will incorporate them in all our practices

> I will need your aggressive assistance in providing educational material, tools, seminars, classes, resources to our patients
>
> Can you do this Monday?

Exhibit 63, incorporated herein. Sidd, in turn, emailed Ward and Relator, asking "Linda/Darren, please email Dr Singh all details of our Diabetes, CHF, CVD and COPD SNP programs by COB on Monday. Thanks, Sidd." But Ward, a year and a half after CMS had mandated a SNP model of care plan, told Sidd that Freedom had no models of care, CM/DM plans, protocols, or anything else to send:

> "Sidd,
>
> There is no way I can get this all pulled together by Monday—I am still writing them."

Exhibit 63. And Sidd, who had co-authored Freedom's SNP applications that promised these very services, was well aware that Freedom had done next to nothing to implement them, as will be discussed herein.

164. Freedom's fraudulent practices began with the representations it made in its SNP applications. For CMS to approve its SNPs, Freedom had to complete a Solicitation for Special Needs Plans Proposal ("Solicitation") for each. The Solicitation is both an evaluative tool and a form of guidance that incorporates elements of CMS policy. Each Solicitation contained multiple certifications, which Freedom did not intend to honor and has not honored, to provide specific care services to SNP beneficiaries. For example, the Solicitation required Freedom to state the goals of its Model of Care, "[d]escribe the specific organization of staff . . . to provide the specialized services available under the Model of Care," "[d]escribe the specific steps the SNP takes (e.g.

written protocols and training) to ensure the staff understands how the Model of Care works and to function in accordance with the Model of Care," "[s]tate how this Model of Care will identify and meet the needs of beneficiaries with severe and disabling chronic conditions," "[l]ist and explain the extra benefits and services" available to those beneficiaries, and "[s]tate what specific process and outcome measures [Freedom] will use to measure performance of the Model of Care." Exhibit 64, incorporated herein. In its answers, Freedom represented that it would develop and staff a model of care in accordance with each of these certifications, and CMS approved Freedom's SNPs on the basis of its representations. As discussed herein, however, Freedom created no model of care, employed too few staff to provide specialized services to its SNP members, developed no protocols or training for implementing the (non-existent) model of care, did not identify or meet its beneficiaries' needs, provided the majority of them with no extra benefits or services, and established no process or outcome measures to monitor performance beyond the minimum basic measuring required of all MA plans. In short, Freedom made no effort to provide the services it had promised in the Solicitations, and which were material to CMS approval.

165. From October 2008 to the present, Freedom managers have received numerous internal warnings from Freedom's health services staff that Freedom was not operating its SNP program in compliance with CMS guidance and regulations, or according to the promises it made in the Solicitations. As Freedom's managers have never intended to follow CMS rules, Freedom continues to devote almost no resources to the SNP, leaving Freedom totally out of compliance with SNP requirements. As a result,

Freedom's hardest-to-treat members, the SNP beneficiaries, have been deprived of the benefits of a true SNP—receiving *coordinated* care that is furnished according to a model of care that considers the beneficiary's individual needs and goals.

166. On October 5, 2008, Pat Petro estimated that Freedom staff had completed only about 300 general assessments, a basic service wherein a case manager calls new members to ask about their conditions, medications, and doctors. Likewise, Petro said that Freedom had performed fewer than 100 disease-specific health assessments, and less than 100 member-specific care plans, for the 7,200 SNP beneficiaries. Exhibit 34 (Relator's notes dated 10/05/08), incorporated herein.

167. On October 13, 2008, Relator met with Sidd Pagidipati and Mital Panara. Relator told Sidd that Freedom had completed only about 100 care plans, when it should have completed care plans for all 7,200 SNP beneficiaries. Relator told Sidd that Freedom needed both 50–100 nurses and an electronic documentation system to fulfill its obligations. Sidd ignored the dramatic need for more nurses, saying merely that he was interested in the documentation system.

168. Relator met with Mital Panara and Patricia Petro on October 16, 2008 to discuss the SNP. Panara told Relator and Petro that he planned to have 15,000 beneficiaries in the SNP next year, as CMS would pay Freedom an extra $125 per member per month above Freedom's regular plan rate. When Petro said she could not manage that many members, Panara said that was her and Relator's problem. Exhibit 10 (Relator's notes dated 10/16/08), incorporated herein.

169. Around the same time, Relator and Linda Ward created a PowerPoint Presentation on the return on investment for CCMS, an electronic documentation system necessary for managing CM/DM services, which they distributed to Dr. Patel, Sidd Pagidipati, and Jigar Desai. The CCMS presentation warned of huge SNP compliance problems. First, Freedom was allocating just four full-time-equivalent nurses and two social workers to the SNP. Along with PPHA, an external medical management company Freedom was using to provide care and disease management ("PPHA"), they had produced fewer than 500 care plans and fewer than 1,200 disease-specific assessments for the already more than 7,200 SNP members. Relator and Ward warned that, with a full-time nurse's case load being 75 beneficiaries, Freedom would have to hire 100 more full-time nurses to perform as promised in the Solicitation. They argued that the CCMS software, if combined with the 10–20x staffing increase, could make Freedom compliant for 2009.

170. Rather than increase staffing, however, Freedom made cuts. On October 1, 2008, Dr. Patel terminated Freedom's contract with PPHA, effective January 1, 2008. Freedom had hired PPHA to provide external CM/DM to SNP beneficiaries, and had invoked its capabilities repeatedly in its Solicitations. In truth, Freedom had only hired PPHA on a penny-pinching, "Volkswagen" contract that could accommodate only a fraction of Freedom's multiplying SNP population. Even so, Freedom became solely responsible for SNP CM/DM by terminating PPHA's contract, yet instead of increasing staff to handle this new workload, it continued to try to make cuts.

171. On November 21, 2008, Relator met with Dr. Patel, Sidd Pagidipati, and Jigar Desai. During the meeting, Dr. Patel told Relator that the Utilization Management Department ("UM"), which evaluates the cost and quality of medical services, was overstaffed. Relator told Dr. Patel that UM was severely understaffed relative to SNP requirements. Dr. Patel persisted, telling Relator to replace two clinical staff with cheaper non-clinical staff. When Relator again protested that UM desperately needed more staff to perform under its CMS contract, Dr. Patel acknowledged his feelings but said to "consider his suggestions." Exhibit 65 (Relator's notes dated 11/21/08), incorporated herein.

172. On December 10, 2008, Relator met with Pradeep Kathi, Freedom's Compliance Officer, to discuss the SNP further. Relator asked Kathi why Freedom had made such ambitious promises in its Solicitations in light of its limited experience and resources. Kathi said that he and Sidd Pagidipati had written the Solicitations, and that they had known when they wrote them that Freedom could never perform the services they were promising. According to Kathi, the representations in the Solicitations were just a means to win CMS approval of the SNP contracts. Though Kathi acknowledged that Freedom "would be dead" if the 2008 SNP were audited, he said the risk of an audit was minimal, and that Freedom should focus on becoming CMS compliant by 2010. Exhibit 66 (Relator's notes dated 12/10/08), incorporated herein.

173. Later that same day, Sidd Pagidipati summoned Relator to meet with him and Rupesh Shah, an unofficial senior advisor to Freedom, about the SNP. Relator told Sidd that Freedom was not performing under the Solicitations, noting that Freedom had

not undertaken many promised CM/DM activities, and had not filled positions it had promised to create. Sidd said "it would be easy to window dress some of this stuff" by giving extra titles to existing staff to create the illusion that Freedom had filled the missing positions. Relator relayed Pradeep Kathi's conclusion that Freedom "would be dead" in an audit, and Sidd agreed. Like Kathi, however, Sidd said that Freedom had little to worry about, and should work toward 2010 compliance. Exhibit 67 (Relator's notes dated 12/10/08), incorporated herein.

174. The next day, Sidd Pagidipati asked Relator if Freedom could cut some staff. Relator reiterated that Freedom was critically understaffed for the SNP. Sidd acknowledged this but said he thought Freedom was "ok" on SNP staffing. Exhibit 68 (Relator's notes dated 12/11/08), incorporated herein.

175. Soon after this meeting, Relator emailed Sidd Pagidipati and Dr. Patel about SNP compliance. In his email, Relator said Freedom was delinquent in several areas, and that Rupesh had asked him to document the delinquencies. In an attached spreadsheet, Relator directed their attention to the 14 most important delinquencies, including Freedom's wholesale failure to identify and address beneficiary needs, and the lack of a transition plan to take over the services PPHA was providing. Exhibit 69, incorporated herein.

176. About a week later, on December 18, 2008, Relator gave a handwritten memo to Jigar Desai, Freedom's Chief Financial Officer. The memo asked for a budgetary allotment for the hiring of the 100 nurses Freedom needed to staff the SNP compliantly. Desai responded with handwritten annotations, saying that Freedom did not

need to hire more nurses because Freedom would not be providing CM/DM to every SNP member, and that the CCMS software program would improve nurse productivity enough to cover those SNP members who would be receiving CM/DM. Exhibit 70, incorporated herein.

177. Freedom ignored Relator's repeated warnings that the SNPs were not being run properly because it had never intended to create real SNPs. Freedom wanted the extra SNP revenue, but was unwilling to invest in the programs and processes needed for a SNP. Freedom's fraudulent solution was to falsely promise those programs and processes in the Solicitations, and then ignore them once CMS had approved their SNP contracts. For example, Sidd Pagidipati emailed Berenice Mesa, Freedom's outside compliance consultant, on January 29, 2009, asking her for some computer screenshots to help Relator prepare Freedom's model of care documents. Exhibit 71, incorporated herein. In its Solicitations, Freedom had promised to enact models of care in 2008, and the 2009 Call Letter expected Freedom to have improved these care models for 2009. And yet Freedom had done nothing until late January 2009, when it began to fear that CMS would discover the missing care models in its next audit.

178. On February 2, 2009, Relator asked Pradeep Kathi, Freedom's Compliance Officer, about which CMS regulations Freedom needed to follow for the SNP. Kathi said that Freedom should have completed everything promised in the solicitation in 2008, and in 2009–2010 needed to comply with the CMS Call Letter and MIPPA, as well as its solicitation promises. Again, Kathi remarked that Freedom would

179. Pradeep Kathi understood that Freedom was systemically non-compliant and at increasing risk of getting caught. In a confidential memorandum to Sidd Pagidipati on February 11, 2009, Kathi spelled out Freedom's problems. First he listed "failures" that CMS knew about. He then turned to Freedom's other deficiencies that CMS might uncover in an audit:

> If we are audited now, we will fail the following audit elements in addition to the concerns listed above:
>
> (1) Enrollment—delays in upload of forms to CMS, delays in sending out required member letters, not acting on member calls requesting cancellation/disenrollment
> (2) Delays in SNP member confirmation of chronic condition
> (3) Not following in Ch 2 timelines on disenrollment of SNP members
> (4) Timely claims payments
> (5) Incorrect member EOBs. This is an element not corrected from the 2007 audit
> (6) Appeals timeframes
> (7) Grievances not logged properly in call logs
> . . .
>
> Some of the deficiencies are being addressed while many are not. We need to correct these deficiencies ASAP. Also, we have to be more conservative and more compliance-oriented in our approach starting now. The risk of non-compliance will be pretty significant, impacting all 4 CMS contracts.

Exhibit 44, incorporated herein.

180. Despite Pradeep Kathi's detailed warning to Freedom's COO, Sidd Pagidipati, Freedom took no corrective action. On February 27, 2009, Linda Ward,

Freedom's Vice President of Health Services, emailed the CM/DM department to tell them to accept no new referrals:

> Hello All,
>
> Just a notice to let you know that as of today - Case and Disease Management Department is closed. There will be no new referrals to CM/DM unless it is an emergency and has been approved by Pat. The CM/DM department will be working on developing their existing cases in order to meet NCQA/CMS guidelines/criteria and also be assisting in the development of their new programs and documentation system.
>
> Linda

Exhibit 72, incorporated herein.

181. On March 2, 2009, Linda Ward told Relator that she had closed the CM/DM Departments due to insufficient staff. Ward had recently lost 2 case managers, leaving her with just 2 case managers and 2 social workers for Freedom's 31,612 total members. Ward said she needed to catch up and implement the CCMS system. Ward said she would reopen CM/DM when she had staff, and that she had informed "the bosses" of this. Exhibit 73 (Relator's notes dated 03/02/09), incorporated herein.

182. With so few staff, Freedom was giving CM to almost none of its members. On January 30, 2009, Freedom had about 200 SNP members actively in CM, out of a total SNP membership of over 13,000. Exhibit 74, incorporated herein. In fact, the total number of SNP members for whom Freedom provided CM between October 1, 2008 and July 21, 2009—both active and closed cases—was just 406.

183. During a SNP staff meeting on April 1, 2009, Pradeep Kathi told the SNP team that Relator had said on numerous occasions that Freedom had not been keeping up with the Solicitations. Exhibit 75 (Relator's notes dated 04/01/09), incorporated herein.

184. On April 3, 2009, Relator emailed Dr. Patel and again voiced his concerns about Freedom's compliance,

> As I have mentioned before, I continue to be concerned regarding the SNP compliance. My day to day duties supervising the UM department leave little time to dedicate to the SNP and Linda, I believe, feels the same. Given the huge size of our SNP's (I believe the two individual SNP's are both in the top 10 largest C-SNP's in the country) we need additional resources to become compliant.

Relator then reminded Dr. Patel about the summary of SNP deficiencies he had sent in December. In the email, he updated that summary to detail Freedom's current SNP compliance problems. Exhibit 76, incorporated herein.

185. The updated summary repeated many of the same deficiencies. Relator reported that Freedom, among other things, still lacked an adequate nursing staff, had no clinically-trained SNP medical director, had not taken over the services PPHA once provided, and was not providing extra services to frail or multiple-illness beneficiaries. Exhibit 76.

186. Also on April 3, 2009, Relator overheard Patricia Petro tell Linda Ward that she (Petro) had just received SNP lab reports for 2008. Ward told Petro that Freedom could now say it had monitored SNP lab reports in 2008. When Relator corrected Ward and said "you mean 2009," Ward said that she meant 2008—Freedom

would doctor its lab reviews to look as though it had done lab reviews in 2008, when in fact it had not. Exhibit 77 (Relator's notes dated 04/03/09), incorporated herein.

187. On May 11, 2009 Relator met with Linda Ward to discuss SNP staffing. Ward told Relator that she had projected the number of man-years it would take to compliantly staff the SNP in 2010. According to Ward, Freedom's 19 clinical staff would be unable to complete the interdisciplinary team meetings, which are just one aspect of SNP management, even if they spent all year working on them and restricted them to just the sickest SNP members. Exhibit 78 (Relator's notes dated 05/11/09), incorporated herein. Soon thereafter, Ward sent a table and organizational chart to Freedom's SNP team that showed the projected deficiency. Exhibit 79, incorporated herein.

188. Around this time, Freedom senior managers Dr. Patel, Sidd Pagidipati, and Rupesh Shah devised a plan to justify providing insufficient care to SNP beneficiaries. Freedom would stratify SNP membership into three layers. Level I, containing the 6,000 healthiest patients, would be managed as a group, with a single care plan (even though the patients have differing conditions), little education, and intervention only through intermittent call center contacts. Level II, holding less healthy patients, would also be managed through a call center, but would receive more calls. To Linda Ward, even Level II plans are "still not true care plans, but hopefully will suffice." Exhibit 80, incorporated herein. Only Level III, comprising Freedom's most critically ill patients, would receive clinical case and disease management. According to Ward's projections, Freedom lacked the staffing to do anything beyond holding interdisciplinary care team meetings for the

Level III beneficiaries. Freedom's stratification plan, therefore, was nothing more than a fresh coat of paint on a rotten house. Freedom bunched members into Level I not because it could manage them as a group, but because it was unwilling to hire the staff to manage them individually.

189. Relator spoke with Linda Ward about her staffing projections again on May 14, 2009. Relator told Ward that the problems she had identified concerned services that Freedom should have been performing in 2009. Ward said "I know. I'm waiting for a huge corrective plan from CMS. A huge list of deficiencies and a huge corrective plan." Ward also noted that no one had replied to her table and organizational chart. Exhibit 81 (Relator's notes dated 05/14/09), incorporated herein.

190. Freedom hired Dr. Michael Yanuck in April 2009 to serve as the medical director for the SNP. Dr. Yanuck reviewed the Freedom SNP and came to the same conclusion as Relator and Linda Ward. In a staff meeting on May 18, 2009, Dr. Yanuck said that Freedom was 1% compliant, in that Freedom was managing only 1% of its membership to any real degree. He said that Freedom would be "dead for the 2009 audit," and that it had not followed through on its 2009 policies and procedures. To Dr. Yanuck, Freedom needed a drastic staffing increase to be compliant in 2010. Relator and Linda Ward then seconded Dr. Yanuck's analysis. They tried to explain to Rupesh Shah, who is closely associated with Dr. Patel and Freedom's upper management, that Dr. Patel's plan to manage the 6,000 Level I members en masse would not meet CMS SNP requirements for 2010. Exhibit 82 (Relator's notes dated 05/18/09), incorporated herein.

191. On May 19, 2009, Relator voiced his concerns about Freedom's plan to manage all Level I members as a single entity to Pradeep Kathi. Kathi implausibly said there were enough commonalities among the 6,000 beneficiaries that they could be grouped together and managed as one. Kathi also downplayed the risk of an audit, saying that CMS auditors would not compare Freedom to the promises it made in the Solicitations.

192. Later that day, Dr. Patel phoned Relator about SNP staffing. Dr. Patel said he had reviewed the concerns that Relator, Linda Ward, and Dr. Yanuck had raised, and felt they were making a mountain out of a molehill. To Dr. Patel, the staffing increases that Relator, Ward, and Dr. Yanuck sought were "absurd" and not cost-effective. When Relator said that CMS expected high service levels for SNP members, Dr. Patel said that was totally ridiculous. Instead of addressing the glaring deficiencies that Linda Ward's staffing projections had spotlighted, Dr. Patel rejected the projections. He told Relator to go back and "review" the projections and find a cheaper way of managing the SNP members. Exhibit 83 (Relator's notes dated 05/19/09), incorporated herein.

193. By now, Relator and others had warned Dr. Patel time and again that Freedom was hopelessly understaffed, and shown him what Freedom needed to do to become compliant. But Dr. Patel had no intention of spending the money necessary for providing the services the SNP program requires. CMS makes a demonstrable monthly payment to Freedom to cover the (ostensible) administrative costs of providing SNP services. Under Dr. Patel, however, Freedom pocketed the extra payments from CMS

instead of using them to deliver the extra services that CMS was paying for. To Dr. Patel, the SNPs were just extra revenue, the better to grow Freedom to a saleable size.

194. Because of Relator's efforts to increase SNP staffing, Freedom threatened to remove him from the SNP project. Late in the day on May 19, 2008, Dr. Patel called for Relator and, in front of Rupesh Shah, angrily told Relator to abandon his thoughts on making the SNP compliant for 2010. Dr. Patel said that Relator needed to redo the SNP plan using less staff. If Relator and Linda Ward continued to have strong feelings about SNP staffing, Dr. Patel said, they could be removed from the SNP project. Dr. Patel suggested that he could assign Relator to some 9,000 Freedom members and give him a measurable goal to improve their MLRs within a couple of months. This was setting Relator up to fail, as the project's timeframe was too short for any intervention to affect MLR, something that Dr. Patel knew very well. As a result of this meeting, Relator knew that his participation on the SNP project, and indeed his future with Freedom, depended on his not objecting to Dr. Patel's decisions about the SNP. Exhibit 84 (Relator's notes dated 05/19/09), incorporated herein.

195. Freedom was working in April and May to develop models of care, however inadequate, because it expected to be audited. On or about April 1, 2009, Freedom learned that CMS had pushed forward a scheduled audit from September to July 13. Freedom feared that a July audit would reveal the true chimerical nature of its SNP program, as it had only recently begun to develop its long-overdue models of care, and now had little time to get them in order. With the audit looming, Freedom scrambled to create the documents it needed to appear compliant for 2009. As discussed above in

¶188, Freedom had just begun devising its "layered" model of care system in April 2009, and it was late May, for example, when Linda Ward produced a draft of Freedom's care models for Level II diabetics. Exhibit 80, incorporated herein. Therefore, it was not until Freedom feared a CMS audit that it finally worked to produce the models of care it had claimed to have had since 2008.

196. To induce CMS into authorizing it to operate a SNP program, Freedom falsely represented in the Solicitations it presented to CMS that it would comply with federal laws and CMS guidance. As evidenced by its continual, pervasive failure to offer SNP services to its members, Freedom never intended to comply with those laws and guiding materials. Freedom decided to operate its SNPs no differently from its other MA plans, pocketing the additional remuneration from CMS without directing resources to the vulnerable beneficiaries the SNP program is supposed to help.

2. False Use of the Evolutions Provider Network to Support Freedom's Expansion Applications, When in Fact it Never Intended to Use the Network to Provide Services.

197. Freedom defrauded the United States by falsely representing its provider network in applications it submitted to CMS to expand its service area. Specifically, Freedom represented to CMS that it had contracted with a provider network to provide services to beneficiaries in the expansion areas. This representation was false, because although Freedom had entered into a contract with the provider network, it never intended to use the network to provide services to its beneficiaries, due to the network's high rates. Freedom carried out this scheme by including the provider network in its expansion application to CMS, and then, once it received authorization from CMS to

expand, removing the network's providers from the list of authorized providers available to its beneficiaries. To ensure that no Freedom employees referred beneficiaries to the network's providers, Freedom hid the existence of the contracts from low-level staff. The result was that Freedom beneficiaries were often left without adequate access to health services. Had CMS known that Freedom would not use the provider network, it would not have approved Freedom's applications to operate MA plans in the expansion areas. Accordingly, the United States has paid numerous false claims to Freedom, and Freedom's beneficiaries have been left without adequate access to health services.

198. For 2008, CMS had authorized Freedom to operate in 17 counties. To continue to grow, Freedom decided in early 2008 to apply to expand into new counties for 2009. Freedom prepared and submitted to CMS a 2009 Service Area Expansion application ("SAE") for Brevard, Charlotte, Clay, Duval, Escambia, Indian River, Jefferson, Lee, Leon, Martin, Polk, St. Lucie, and Volusia counties. CMS reviewed and approved Freedom's SAE. Freedom expanded into the thirteen new counties effective January 1, 2009, giving it a total service area of thirty counties.

199. Unlike traditional fee-for-service Medicare, in which beneficiaries can receive benefits from any provider who accepts Medicare, MA plans can limit their members to receiving benefits through providers that the MA plan has contracted with. Because of this, CMS scrutinizes MA plan applications to ensure that the proposed plan's provider network will offer beneficiaries access to all essential health services. Access denotes both having available the necessary physicians, specialists and hospitals, and having those resources within geographical reach. Accordingly, when an MA plan files a

SAE for a new county, the SAE must show CMS that the MA plan has a sufficient provider network in the new county that beneficiaries would be able to access. The county provider network cannot have gaps, such as a lack of dermatologists, unless the MA plan can demonstrate to CMS that its beneficiaries are close enough to a provider in another county that they can easily access the service there.

200. Freedom knew it could not contract with enough providers for CMS to approve expansion for all thirteen counties in 2009. Therefore, to complete the SAE, Freedom decided to "rent" an existing provider network to fill in the providers it was missing. Rather than use providers from the rental network after approval, however, Freedom would continue to assemble a complete provider network from scratch, leaving many coverage holes that Freedom would fill in over time.

201. MA organizations inform CMS about their provider networks through health service delivery ("HSD") tables. These tables are organized by county, and list every primary care physician, specialist, hospital, laboratory, and clinic in the MA organization's county network. Freedom had to submit HSD tables in its SAE to show CMS that it had complete provider networks in the counties it planned to expand into. Because Freedom did not have complete provider networks when it submitted the SAE, it listed providers from the rental network in the SAE HSD tables.

202. Aside from submitting its HSD tables to CMS, Freedom limits their distribution to its upper management. Freedom maintains a separate, public provider network list for its lower-level staff, providers, and beneficiaries, which it publishes through its website. Thus when Freedom's members want to pick a doctor, they must

choose from the doctors on the public list. Using these separate provider lists, however, Freedom has been able to represent to CMS that it has a complete provider network, while at the same time offering its staff, doctors, and members a different, smaller network that is filled with coverage gaps. CMS—the only outsider that sees the HSD tables—generally does not discover such discrepancies until it conducts an audit, if then. The secrecy of the HSD tables, therefore, has allowed Freedom to tell CMS that its provider networks are complete when in fact they are not.

203. The rental network Freedom hired was Evolutions Healthcare Systems, Inc. ("Evolutions"), a preferred provider organization that maintains contracts with providers across Florida. By contracting with Evolutions, insurers gain access to its network of providers without having to develop such a network themselves. MA organizations do not normally contract with Evolutions, however, because Evolutions' providers charge higher rates than most Medicare providers. As such, Evolutions' clientele is almost exclusively commercial insurers.

204. In the SAE Freedom submitted to CMS, Freedom said it would rely heavily on the Evolutions provider network to serve beneficiaries in many expansion counties. For example, of the 104 providers Freedom listed in its HSD tables for Duval County, 87 were Evolutions providers. Exhibit 85, incorporated herein. Among the Evolutions providers were vital specialists, such as oncologists, that seniors frequently need to access for critical care. Even in counties where Freedom had contracted with larger numbers of non-Evolutions providers, Freedom still used Evolutions to plug the remaining gaps.

205. Freedom never intended to use Evolutions providers to serve its members, however, because those providers charged higher rates than Freedom was willing to pay. By submitting to CMS the SAE that falsely claimed that Freedom would use Evolutions providers for its provider network, Freedom defrauded Real Parties. Freedom's scheme was to hire Evolutions to improve the odds that CMS would approve the SAE. Using Evolutions would make Freedom appear to have complete provider networks, when the networks it would actually offer its beneficiaries were undeveloped and riddled with gaps. Once CMS had approved the SAE on the basis of this falsehood, Freedom intended to remove, and ultimately did remove, the Evolutions providers from its published provider networks, and did not give its beneficiaries access to them, all the while listing them in its HSD tables. For example, Freedom could not find an oncologist to contract with in Duval County, so it patched that critical hole with Evolutions oncologists whom it never intended to use and in fact hid from its beneficiaries. *See* ¶¶0–214.

206. In early 2009, Relator had a phone conversation with Mark Barrett, an employee of Universal Healthcare, Inc. ("Universal"), one of the largest MA organizations in Florida, and a Freedom competitor. During the conversation, Barrett marveled at how Freedom—which is much smaller than Universal—had managed to expand into the counties it did. Barrett said that Universal had been trying to expand into Volusia and Indian River counties, for example, but had not been able to access the local hospitals it needed to convince providers to sign contracts with it. As Relator later discovered, Freedom had expanded into Volusia and Indian River counties by hiring Evolutions. Of the 55 Indian River specialists Freedom listed in the SAE, 53 were from

the Evolutions network. Of the 116 providers in Volusia County, 76 were with Evolutions. Exhibit 86 (SAE HSD tables for Indian River and Volusia counties), incorporated herein. These providers appeared in Freedom's HSD tables, but not in the published provider list that Freedom gave to its members and network doctors. The Indian River Medical Center, one of Freedom's two hospitals in that county, is an Evolutions provider.

207. On April 2, 2009 Relator received a phone call from Dr. David Pinzler, a primary care physician, complaining about the sparseness of Freedom's provider network in Martin and St. Lucie Counties. Dr. Pinzler wrote Relator an email to follow up, and reported:

> AS PER OUR CONVERSATION OF 2 APR 2009, THERE ARE GAPS IN THE SPECIALIST COVERAGE IN MARTIN AND ST. LUCIE COUNTIES. ALLERGY, ENDOCRINOLOGY, ENT, GENERAL SURGERY, HEME-ONC, AND ESPECIALLY RADIOLOGY ARE COMPLETELY WITHOUT REPRESENTATION. I WOULD BE GLAD TO PROVIDE SOME NAMES TO CONSIDER IF THAT WOULD BE HELPFUL.
>
> DAVID PINZLER D.O.

Exhibit 87, incorporated herein.

208. Freedom expanded into Martin and St. Lucie counties on January 1, 2009, using the Evolutions provider network. In the SAE HSD tables, Freedom had listed one allergist, three ENT specialists, three general surgeons, and two radiologists in Martin County. For St. Lucie County, Freedom had claimed to have one endocrinologist, two ENT specialists, two general surgeons, and three radiologists. All were from the Evolutions network. Exhibit 88 (SAE HSD tables for Martin and St. Lucie counties),

incorporated herein. Dr. Pinzler's email, sent just four months after Freedom had expanded into Martin and St. Lucie counties, shows that Freedom was hiding these Evolutions providers, whom it had told CMS were in its network, from its beneficiaries, by purposefully omitting them from the provider list it gave to its beneficiaries and to network doctors like Dr. Pinzler. Had CMS known of the provider gaps Dr. Pinzler identified, it would not have authorized Freedom to expand into Martin and St. Lucie counties.

209. The same day, Relator spoke with Lucy O'Connor, Freedom's Vice President of Claims and Configurations, about Evolutions. O'Connor said that Freedom had never intended to use Evolutions providers because they charged commercial rates, but had nonetheless listed them in its SAE so it would have enough hospitals and providers to "pass." O'Connor said this scheme was Sidd Pagidipati's idea, and that Sidd was handling the Evolutions contract himself. Exhibit 89 (Relator's notes dated 04/02/09), incorporated herein.

210. Relator ran into Jairo Ribero, Freedom's Executive Director for South Florida, on April 3, 2009, and told him about Dr. Pinzler's complaint. Ribero confirmed that Freedom had gaps in its Treasure Coast provider network. When asked about Evolutions, Ribero said (paraphrase) "we only used Evolutions for the application process and stopped using them right after the process was over." Exhibit 90, (Relator's notes dated 04/03/09), incorporated herein. According to Ribero, Freedom had planned to assemble its provider networks *after* CMS had approved its SAE.

211. Pursuing the matter, Relator asked Chris Curtis, a Freedom Provider Operations Representative, about Evolutions on April 6, 2009. Like Lucy O'Connor and Jairo Ribero, Curtis said that Freedom used Evolutions providers for its SAE but not on a day-to-day basis for its members. Exhibit 91 (Relator's notes dated 04/06/09), incorporated herein.

212. Others in Freedom had already observed that Freedom's actual provider networks were quite different from the networks listed in its HSD tables. On February 11, 2009, Freedom's Compliance Officer Pradeep Kathi wrote a memorandum to Sidd Pagidipati, warning him about Freedom's provider network deficiencies:

> If we are audited now, we will fail the following audit elements . . . :
> . . .
> (8) HSD Tables—current HSD tables will not match at all with 2009 SAE application and could raise network adequacy issues.

Exhibit 44.

213. Toward the end of April, a Freedom beneficiary in Duval County needed to see an oncologist. Though Freedom had told CMS in its SAE HSD tables that it would have six oncologists in its Duval County network, they were all affiliated with Evolutions, and therefore Freedom had not included them in the list of authorized Duval County providers it gave to its low-level staff and beneficiaries. As a result, Freedom appeared to have no oncologist in Duval County, and Freedom employees spent weeks canvassing the county for an out-of-network oncologist willing to see the Freedom beneficiary. Reacting to this situation, Linda Ward emailed Freedom's managers on May 12, 2009:

> So we have no par oncology in Duval? That is a large county!! How can we have membership there without an oncologist??
>
> Doris has struck out with even negotiating with providers. I had suggested she offer them Medicare allowable + 115% for office and drugs, but they won't even negotiate.
>
> Clay and Duval are too far to go to Shands. Are there any oncology groups that are only hospital based at one of the large centers that you could contact?

Exhibit 92, incorporated herein.

214. Freedom had no oncologist in Clay or Duval County because it had fraudulently used Evolutions oncologists for its SAE, listing them in its HSD tables, and then omitted them from its published provider lists. Responding to the same situation, Relator emailed Tammy Castano, Freedom's Provider Operations Director, on May 13, 2009: "Who did we use for our application? If you have a group name I'll give them a holler and see if we can re-convince them to see our members." Castano replied, "[I] think we used the rental network (Evolutions) initially." Exhibit 93, incorporated herein. Therefore, Castano knew that Freedom had a contract with the Evolutions oncologists, and could have sent the beneficiary to see them. Indeed, Freedom still listed the Evolutions oncologists in its Duval County HSD tables as of April 21, 2009. Exhibit 94 (HSD tables for Duval and Clay counties), incorporated herein. But Castano also knew she was not allowed to refer beneficiaries to Evolutions providers, because of their high commercial rates, and thus did not make them available. Freedom facilitated this concealment by not making the HSD tables it sends to CMS available to non-senior staff.

215. Meanwhile, Freedom's provider network in the Treasure Coast area was still missing critical, basic specialties that Freedom had claimed to have possessed in its SAE. On May 28, 2009, Dr. Pinzler left Relator a voicemail about his increasing frustration with Freedom's continuing problems:

> This is Dr. David Pinzler. I've spoken to you before about their lack of radiology, and now I have another patient who needs a mammogram; she needs a bone density, and she can't get it because she has to travel 1,000 miles from Martin County. It's totally ridiculous. You blew me off last time and said, "We're working on it; we're working on it." Well, that obviously was baloney because nothing's happened. So, you know you sell these people insurance, and then they can't get what they need, so how do you figure this works. My phone number is 772-419-5904. It's 1:20 on Thursday, the 28th. Goodbye.

Exhibit 95, incorporated herein. Freedom had listed radiologists in Martin County in its SAE, but Dr. Pinzler, a Freedom primary care provider, had no knowledge of them.

216. Freedom managers hid their fraudulent practices in part by selectively removing Evolutions providers from participation in an internal audit. On May 18, 2009, Carole Frank, the Compliance Officer for Optimum Healthcare (an HMO that Dr. Patel owns and has closely integrated with Freedom), emailed senior Freedom staff, including Chris O'Connor, Freedom's Senior Vice President of Operations, and Tammy Castano, Freedom's Provider Operations Director, to inform them that Freedom/Optimum's Compliance Unit would be conducting a CMS-mandated internal audit of Freedom's and Optimum's credentialing and contracting practices. Frank wrote that, as part of the audit, the Compliance Unit would review a representative sample of provider contracts, and that

"[w]e have randomly selected 1 provider for each county in our service area for the audit." Exhibit 96, incorporated herein.

217. Among the providers randomly chosen from Freedom's HSD tables, however, were two Evolutions doctors. Tammy Castano, who knew Freedom was not using Evolutions providers, instructed Carole Frank to not audit the Evolutions doctors:

> Carol,
>
> This is the status thus far. . . .
>
> We have two files—on Freedom out of Duval and Escambia that appear to be Evolutions (our rental network). Duval, please make another selection. Escambia—see Chris O [O'Connor].

Exhibit 96. Frank, not understanding why Freedom wanted to handle its Evolutions providers differently from its other providers, asked for an explanation:

> I'm confused. Is there a reason we don't want to do "Evoloutions"? [*sic*] We delegate (rent??) to them—as are the providers they contract with. They were reviewed last year—something different this year?

Id. Minutes later, Chris O'Connor responded—this time not copying Castano or anyone else—to tell Frank to speak with him in person:

> Carol, I will be there at Church [a Freedom office] . . . I will educate you about Evolutions.
>
> Chris

Id. Soon after their meeting, Frank emailed Chris O'Connor her misgivings about Freedom's decision not to audit the Evolutions providers:

> I kinda understand.....remember, we are using the HSDS tables submitted to CMS and the State. That means that either can pull an Evolutions folder .....If we say

> they are in the network, we have to be prepared to have them audited.

Id. Soon thereafter, Frank wrote Pradeep Kathi, her counterpart at Freedom: "Do you know something I don't about this?" *Id.*

218. CMS's approval for Freedom to expand was the direct result of Freedom misrepresentations. As it evaluated Freedom's SAE, CMS determined that it needed Freedom to submit additional information on multiple issues, including its relationship with Evolutions. In an April 15, 2008 letter, CMS instructed Freedom to "[c]larify the relationship between Applicant [Freedom], Evolutions Healthcare System & Guardian Resources, Inc." Exhibit 97, incorporated herein. (Evolutions was formerly named Guardian Resources.) Specifically, CMS asked: "Does an administrative & management services agreement exist between Applicant (Freedom Health), Evolutions and Guardian?" CMS also observed in the letter that the contract signature page Freedom had submitted for Shands Hospital was between Shands and Evolutions, not Freedom. CMS therefore told Freedom to "[s]ubmit documentation that legally ties this contractual relationship to Applicant (Freedom Health, Inc.)." CMS reminded Freedom that it "must provide evidence to CMS that it has an adequate network of healthcare providers to ensure access, availability and continuity of care for all Medicare covered services." Furthermore, CMS made clear that its evaluation of Freedom's SAE application depended on Freedom's written submissions: "[CMS] will rely on your application, including the materials you submit in response to this letter, to determine your organization's compliance." By submitting information to CMS about its relationship

with Evolutions without disclosing that it would not use Evolutions to provide services to its members, Freedom fraudulently induced CMS into approving its SAE.

219. The inability of Freedom beneficiaries to receive essential services has been the direct result of Sidd Pagidipati's fraudulent efforts to boost revenue by expanding Freedom's service area, on the strength of a Potemkin provider network, without worrying about having an actual network in place. By filing the false SAE, Freedom reversed the CMS expansion process: it could assemble provider networks at its leisure, knowing that CMS had already approved it to operate in the new areas. Freedom fraudulently induced CMS to grant expansion it would never have approved had it known the truth, i.e., that Freedom did not intend to use, and did not use, the rental network while it assembled its own. The cost of Freedom's scheme fell on its beneficiaries, who quickly learned that the gaps in Freedom's coverage were many, and easy to fall into.

COUNT I

Substantive Violations of the Federal False Claims Act 31 U.S.C. §§ 3729(a)(1)(A)–(C), (a)(1)(G), and 3732(b)

220. Relator realleges and incorporates by reference the allegations made in Paragraphs 1 through 219 of this Complaint.

221. This is a claim for treble damages and forfeitures under the Federal False Claims Act, 31 U.S.C. §§ 3279–33, as amended.

222. Through the acts described above, defendants Freedom Health, Inc., America's 1st Choice Holdings of Florida LLC, Liberty Acquisition Group LLC, Health Management Services of USA LLC, Global TPA LLC, Dr. Kiranbhai C. Patel, and Dr.

Devaiah Pagidipati ("Defendants"), their agents, employees, and co-conspirators, knowingly presented, or caused to be presented, to the United States false and fraudulent claims, and knowingly failed to disclose material facts, in order to obtain payment or approval from the United States and its contractors, grantees, and other recipients of its funds.

223. Through the acts described above, Defendants, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements, which also omitted material facts, in order to induce the United States to approve and pay false and fraudulent claims.

224. Through the acts described above, Defendants, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements material to an obligation to pay and transmit money to the United States, and knowingly concealed and improperly avoided and decreased an obligation to pay and transmit money to the United States.

225. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

226. By reason of the payment made by the United States, as a result of Defendants' fraud, the United States has suffered millions of dollars in damages and continues to be damaged.

COUNT II

Substantive Violations of the Florida False Claims Act
Fla. Stat. § 68.082(2)(a), (2)(b), and (2)(g)

227. Relator realleges and incorporates by reference the allegations made in Paragraphs 1 through 226 of this Complaint.

228. This is a claim for treble damages and penalties under the Florida False Claims Act, Fla. Stat. §§ 68.081–.092.

229. Through the acts described above, defendants Freedom Health, Inc., America's 1st Choice Holdings of Florida LLC, Liberty Acquisition Group LLC, Health Management Services of USA LLC, Global TPA LLC, Dr. Kiranbhai C. Patel, and Dr. Devaiah Pagidipati ("Defendants"), their agents, employees, and co-conspirators, knowingly presented and caused to be presented to the Florida State Government, including without limitation the Agency for Health Care Administration ("AHCA"), and its officials false and fraudulent claims, and knowingly failed to disclose material facts, in order to obtain payment and approval from the Florida State Government.

230. Through the acts described above, Defendants, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements, which also omitted material facts, in order to induce the Florida State Government, including without limitation AHCA, to approve and pay false and fraudulent claims.

231. Through the acts described above, Defendants, their agents, employees, and co-conspirators, knowingly made, used, and caused to be made and used false records and statements to conceal, avoid, and decrease obligations to pay and transmit money to the Florida State Government, including without limitation AHCA.

232. The Florida State Government, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, their agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

233. By reason of the payment made by the Florida State Government as a result of Defendants' fraud, the Florida State Government has suffered damages and continues to be damaged.

234. The Florida State Government is entitled to the maximum penalty of $11,000 for each and every violation of Fla. Stat. § 68.082 alleged herein.

PRAYER

WHEREFORE, *qui tam* plaintiff Dr. Darren A. Sewell, M.D. prays for judgment against the defendants Freedom Health, Inc., America's 1st Choice Holdings of Florida LLC, Liberty Acquisition Group LLC, Health Management Services of USA LLC, Global TPA LLC, Dr. Kiranbhai C. Patel, and Dr. Devaiah Pagidipati ("Defendants") as follows:

1. That Defendants cease and desist from violating 31 U.S.C. §§ 3279–33 and Fla. Stat. §§ 68.081–.092;

2. That the Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States has sustained as a result of Defendants' actions in violation of the Federal False Claims Act, as well as a civil penalty of $10,000 for each violation of 31 U.S.C. § 3729;

3. That the Court enter judgment against Defendants in an amount equal to three times the amount of damages the State of Florida has sustained because of

Defendants' actions in violation of the Florida False Claims Act, as well as a civil penalty of $11,000 for each violation of Fla. Stat. § 68.082(2);

4. That Relator be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) of the Federal False Claims Act, and Fla. Stat. § 68.085 of the Florida False Claims Act;

5. That Relator be awarded all costs of this action, including attorneys' fees and expenses; and

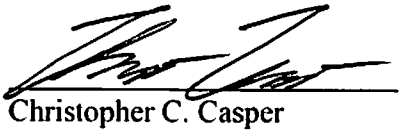
6. That the United States and the State of Florida, and each of them, and Relator receive all such other relief as the Court deems just and proper.

JURY DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator hereby demands trial by jury.

DATED: August 17, 2009

Respectfully submitted,



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CERTIFICATE OF SERVICE

I hereby certify that, pursuant to 31 U.S.C. § 3730(b)(2), I will mail a true and accurate copy of the foregoing Complaint to the below persons via U.S. mail on this 18th day of August, 2009, at the following addresses:

Eric H. Holder Jr.
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U.S. Department of Justice
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Washington, DC 20530-0001

Bill McCollum
Attorney General
Office of the Attorney General
The Capitol PL-01
Tallahassee, FL 32399-1050

A. Brian Albritton
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JS 44 (Rev. 12/07)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON THE REVERSE OF THE FORM.)

I. (a) PLAINTIFFS

United States and the State of Florida ex rel. Dr. Darren A. Sewell

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorney's (Firm Name, Address, and Telephone Number)
Christopher C. Casper (Florida Bar No. 48320), James, Hoyer, Newcomer & Smiljanich, P.A., 4830 West Kennedy Boulevard, Suite 550, Tampa, Florida 33609, Phone: 813-286-4100

DEFENDANTS

Freedom Health, Inc., America's 1st Choice Holdings of Florida LLC, Liberty Acquisition Group LLC, Health Management Services of USA LLC, Global TPA LLC, Dr. Kiranbhai C. Patel, and Dr. Devaiah Pagidipati

County of Residence of First Listed Defendant Hillsborough
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE LAND INVOLVED.

Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☒ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated or Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated and Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excl. Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury

PERSONAL INJURY
- ☐ 362 Personal Injury - Med. Malpractice
- ☐ 365 Personal Injury - Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 444 Welfare
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 440 Other Civil Rights

PRISONER PETITIONS
- ☐ 510 Motions to Vacate Sentence

Habeas Corpus:
- ☐ 530 General
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition

FORFEITURE/PENALTY
- ☐ 610 Agriculture
- ☐ 620 Other Food & Drug
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 630 Liquor Laws
- ☐ 640 R.R. & Truck
- ☐ 650 Airline Regs.
- ☐ 660 Occupational Safety/Health
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Mgmt. Relations
- ☐ 730 Labor/Mgmt.Reporting & Disclosure Act
- ☐ 740 Railway Labor Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Empl. Ret. Inc. Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 463 Habeas Corpus - Alien Detainee
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 810 Selective Service
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 875 Customer Challenge 12 USC 3410
- ☒ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 892 Economic Stabilization Act
- ☐ 893 Environmental Matters
- ☐ 894 Energy Allocation Act
- ☐ 895 Freedom of Information Act
- ☐ 900Appeal of Fee Determination Under Equal Access to Justice
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN (Place an "X" in One Box Only)

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from another district (specify) ☐ 6 Multidistrict Litigation ☐ 7 Appeal to District Judge from Magistrate Judgment

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing **(Do not cite jurisdictional statutes unless diversity):**
Federal False Claims Act, 31 U.S.C. §§ 3729 et seq.

Brief description of cause:
Action to recover damages and penalties for false claims submitted to the United States.

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER F.R.C.P. 23

DEMAND $ Over $1 million

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE 8/17/09

SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____